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 apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 11, 2015	2015_189120_0030	H-001916/1918/1919-15	Follow up

Licensee/Titulaire de permis

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

BENNETT HEALTH CARE CENTRE
1 Princess Anne Drive Georgetown ON L7G 2B8

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 23, 24, 2015

During an inspection (2014-265526-0018) conducted August 15-29, 2014, non-compliance was identified and Orders issued related to bed safety (#005), equipment maintenance (#004) and the resident-staff communication and response system (#002). For this follow-up visit, the conditions laid out in Orders #005 and #004 were not fully met and revised Orders are being issued. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Administrator Assistant, Director of Care and personal support workers. The Inspector toured most resident rooms, tested bed rails, tested the resident-staff communication and response system and associated staff procedures, reviewed resident health care records, reviewed maintenance policies and procedures and written records of repair.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Infection Prevention and Control
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **4 WN(s)**
- **2 VPC(s)**
- **2 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. 17. (1)	CO #002	2014_265526_0018	120

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,
(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee did not ensure that there were schedules and procedures in place for preventive and remedial maintenance related to indoor furnishings and surfaces such as but not limited to walls, doors, floors, vanities and ceilings.

During the inspection of the home, resident rooms, bathrooms, common shower rooms and tub rooms were visited and evaluated for condition. It was identified that many of the resident washroom counter tops (2107, 2125, 2135, 2134, 2137) were in poor condition, with sections of the laminate coming away from the base near the sinks. Two tub rooms had wall damage (wall tiles missing, hole in wall just above the floor approximately 30 cm long). Resident's dressers were missing surface laminate in 2158, 2125, 2042, 2034, 2050.

The licensee's maintenance policy 18.1 dated March 2015 identified as "Maintenance Services - Preventive" identified that "the maintenance program involved the systematic inspection, detection, correction and prevention of failures before they become actual or major failures". Under one of the "key elements" of the home's maintenance program, it identified that a "50 point audit would be used to assess room condition" and that "housekeeping also had a similar audit". The Administrative Assistant provided the housekeeping audits completed by housekeeping staff in January 2015 for review. The audit did not include condition of the resident room vanities or the condition of the surfaces and fixtures inside of the bathing areas or an audit of any common area. Housekeeping staff who completed the audits of resident rooms in January 2015 also reported that the same dressers identified above were missing laminate. No follow-up

action or schedule for repair had been developed according to the Assistant Administrator.

The licensee's maintenance policy did not include any procedures as to how furnishings and surfaces such as walls, doors, floors, vanities and ceilings would be maintained, who would be responsible for the repairs, what the expected condition for the furniture or surface was and how often the audits would be completed. [s. 90(1)(b)]

2. The licensee did not ensure that procedures were developed to ensure that all equipment, specifically beds were kept in good repair.

The home's maintenance policy did not include any procedures with respect to how bed systems would be maintained. At the time of the visit, a preventive inspection program for the beds had not been implemented. The preventive maintenance program would require a person to follow the bed manufacturer's requirements to audit various bed components at the suggested frequencies. The maintenance program at the time of inspection was largely dependent on nursing staff to identify and report beds in disrepair during their shift. An audit identifying which beds were non-functional could not be supplied during the inspection but the licensee was aware that some beds required new parts.

During the inspection, a number of bed rails were tested and found to be very loose. Bed rails on beds in rooms #2045-1, 2045-2, 2050-1 and 2024 were very loose, moving back and forth away from the mattress and creating a hazardous condition. The type of bed rails were identified as rotating assist rails. The home had several bed models with rotating assist rails, however one model in particular was of a particular concern because of the type of attaching hardware. Some bed models had bed rails that were attached to the frame of the bed with a metal plate and one large screw (other bed models had two screws), which would loosen a short time after it was tightened with minimal use. The bed rails tested easily moved back and forth thereby creating gaps.

The licensee confirmed after the inspection was completed that 3 beds required replacement parts and that the 7 beds previously identified as non-functional (during an inspection in August 2014) had been repaired. The 3 electric beds were not operational (head of bed could not be elevated or the entire bed could not be elevated) due to a motor or junction box issue. According to the Associate Administrator, parts were ordered from the bed manufacturer in November 2014 and were still on back order. They were not able to secure the parts from other bed manufacturers. In the interim, the licensee re-allocated the non-elevating beds to residents who did not require head

elevation or a bed in the lowest position. The licensee did not have any specific plans to order new beds should replacement parts not be available.

Compliance Order #004 was previously issued for an inspection (2014-265526-0018) conducted between August 15-29, 2014 related to the lack of developed procedures and processes to maintain equipment in good repair. The conditions laid out in the previous Order were not fully met during this inspection. [s. 90(2)(b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". 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 schedules and procedures are in place for preventive and remedial maintenance related to indoor furnishings and surfaces such as but not limited to walls, doors, floors, vanities and ceilings, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee did not ensure that residents who used bed rails were assessed in accordance with prevailing practices to minimize risk to the resident, taking into consideration all potential zones of entrapment. Prevailing practices have been identified by the Ministry of Health and Long Term Care as those developed by Health Canada related to bed safety.

According to the Director of Care, residents were not assessed using guidelines titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and endorsed by Health Canada). According to the guidance document, residents need to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail(s) are a safe alternative for the resident after trialling other options. Factors such as the status of the bed system, residents' sleep patterns, habits, medication use, cognition, communication, risk of falling and many other considerations need to be considered.

No template, decision tree or questionnaire had been developed to ensure a consistent and complete assessment of each resident which would also have included input from personal support workers and physiotherapists. The assessment that was completed included the resident's bed system, and included whether the resident's bed passed or failed all four zones of entrapment. During the inspection, residents were observed to be sleeping in 6 identified beds with one or both rails elevated (guard position). A review of the plan of care for the identified residents revealed that two had a notation that they were to have 2 bed rails up while in bed for safety, but no assessment identified exactly what the safety reasons were. The remaining 4 residents did not have any bed rail information identified in their plan of care. None of the residents had any documented assessments as to why bed rails were needed (repositioning, bed mobility, restraint etc) and whether other options were trialled before applying the bed rails.

Compliance Order #005 was previously issued for an inspection (2014-265526-0018) conducted between August 15-29, 2014 related to a lack of resident assessments to minimize risks to the resident where bed rails were used. The conditions laid out in the previous Order were not fully met during this inspection. [s. 15(1)(a)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).
2. Skin and wound care. O. Reg. 79/10, s. 221 (1).
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).
4. Pain management, including pain recognition of specific and non-specific signs of pain. O. Reg. 79/10, s. 221 (1).
5. For staff who apply physical devices or who monitor residents restrained by physical devices, training in the application, use and potential dangers of these physical devices. O. Reg. 79/10, s. 221 (1).
6. For staff who apply PASDs or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs. O. Reg. 79/10, s. 221 (1).

Findings/Faits saillants :

1. Training was not provided to all staff who provided direct care to residents and who applied Personal Assistance Services Devices (PASDs)or monitor residents with PASDs, training in the application, use and potential dangers of the PASDs.

Personal support workers who were interviewed on April 23, 2015 were asked why residents had their bed rails elevated (guard position) while in bed and if there was any specific directive or document that specified that a PASD was required. Various responses were received but the predominant answer was that they did not refer to any plan of care or directive for the resident but instead had personal knowledge that the resident needed a bed rail based on the residents' habits and personalities. Some personal support workers did not seem aware of the fact that a bed rail could pose a potential risk for various reasons. Some staff did not recall attending any educational sessions on bed rail entrapment hazards and some did.

According to the Director of Care, education was not provided to all health care staff regarding bed rail safety hazards since the last inspection conducted in August 2014. [s. 221(1)]

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 staff who apply Personal Assistance Services Devices (bed rails) receive training in the application, use and potential dangers of the PASD, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (9) The licensee shall ensure that there is in place a hand hygiene program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, and with access to point-of-care hand hygiene agents. O. Reg. 79/10, s. 229 (9).

Findings/Faits saillants :

1. The hand hygiene program was not implemented in accordance with prevailing practices as identified in a document titled "Best Practices for Hand Hygiene in all Health Care Settings, April 2014".

According to the document, hand wash sinks must be accessible to staff and dedicated to hand hygiene and used for no other purpose. During the inspection of both tub rooms and the shower room in the home on April 22, 2015, none of the dedicated hand wash sinks was accessible for hand washing purposes. The hand wash sinks in both the North tub room and the East shower room were full of stacked clean towels. The east tub room had a tub cleaning brush in it and a box of gloves on the side of the sink which easily fell into the sink. Although staff were not witnessed in the bathing areas, staff would not have been able to use any of the hand wash sinks for hand hygiene after providing care to residents. [s. 229(9)]

Issued on this 11th day of May, 2015

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministére 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

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) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2015_189120_0030
Log No. / Registre no:	H-001916/1918/1919-15
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 11, 2015
Licensee / Titulaire de permis :	BENNETT HEALTH CARE CENTRE 1 Princess Anne Drive, Georgetown, ON, L7G-2B8
LTC Home / Foyer de SLD :	BENNETT HEALTH CARE CENTRE 1 Princess Anne Drive, Georgetown, ON, L7G-2B8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Brian Jackson

To BENNETT HEALTH CARE CENTRE, 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: 2014_265526_0018, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;
(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;
(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;
(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and
(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

Order / Ordre :

The licensee shall;

1. Develop a procedure for the preventive maintenance of all beds. The procedure shall include the manufacturer's requirements and describe how the beds will be audited, by whom and how often.
2. Complete an inspection of all beds in the home and document the bed serial number, the date, the name of the auditor, the components inspected, findings, follow up actions taken and date those actions were taken.
3. Identify and mitigate all beds with loose bed rails so that they do not present a hazard to the resident using them.

Grounds / Motifs :

1. The licensee did not ensure that procedures were developed to ensure that all equipment, specifically beds were kept in good repair.

The home's maintenance policy did not include any procedures with respect to how bed systems would be maintained. At the time of the visit, a preventive inspection program for the beds had not been implemented. The preventive maintenance program would require a person to follow the bed manufacturer's requirements to audit various bed components at the suggested frequencies. The maintenance program at the time of inspection was largely dependent on nursing staff to identify and report beds in disrepair during their shift. An audit identifying which beds were non-functional could not be supplied during the inspection but the licensee was aware that some beds required new parts.

During the inspection, a number of bed rails were tested and found to be very loose. Bed rails on beds in rooms #2045-1, 2045-2, 2050-1 and 2024 were very loose, moving back and forth away from the mattress and creating a hazardous condition. The type of bed rails were identified as rotating assist rails. The home had several bed models with rotating assist rails, however one model in particular was of a particular concern because of the type of attaching hardware. Some bed models had bed rails that were attached to the frame of the bed with a metal plate and one large screw (other bed models had two screws), which would loosen a short time after it was tightened with minimal use. The bed rails tested easily moved back and forth thereby creating gaps.

The licensee confirmed after the inspection was completed that 3 beds required

replacement parts and that the 7 beds previously identified as non-functional (during an inspection in August 2014) had been repaired. The 3 electric beds were not operational (head of bed could not be elevated or the entire bed could not be elevated) due to a motor or junction box issue. According to the Associate Administrator, parts were ordered from the bed manufacturer in November 2014 and were still on back order. They were not able to secure the parts from other bed manufacturers. In the interim, the licensee re-allocated the non-elevating beds to residents who did not require head elevation or a bed in the lowest position. The licensee did not have any specific plans to order new beds should replacement parts not be available.

Compliance Order #004 was previously issued for an inspection (2014-265526-0018) conducted between August 15-29, 2014 related to the lack of developed procedures and processes to maintain equipment in good repair. The conditions laid out in the previous Order were not fully met during this inspection. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

Order # / Ordre no : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_265526_0018, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall;

1. Develop a comprehensive bed safety assessment tool or form using as a guide the US Federal Food and Drug Administration document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings, April 2003".
2. An interdisciplinary assessment of all residents using the bed safety assessment tool shall be completed and the results and recommendations of the assessment shall be documented.
3. Update all resident health care records to include why bed rails are being used, how many are to be used and any accessories that are required to mitigate any identified entrapment or safety risks.
4. Educate all health care staff with respect to when to apply bed rails for each resident, why they are being applied and general bed safety hazards.

Grounds / Motifs :

1. The licensee did not ensure that residents who used bed rails were assessed in accordance with prevailing practices to minimize risk to the resident, taking into consideration all potential zones of entrapment. Prevailing practices have

been identified by the Ministry of Health and Long Term Care as those developed by Health Canada related to bed safety.

According to the Director of Care, residents were not assessed using guidelines titled “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003” (developed by the US Food and Drug Administration and endorsed by Health Canada). According to the guidance document, residents need to be evaluated while sleeping in bed over a period of time by an interdisciplinary team to determine if the bed rail(s) are a safe alternative for the resident after trialling other options. Factors such as the status of the bed system, residents' sleep patterns, habits, medication use, cognition, communication, risk of falling and many other considerations need to be considered.

No template, decision tree or questionnaire had been developed to ensure a consistent and complete assessment of each resident which would also have included input from personal support workers and physiotherapists. The assessment that was completed included the resident's bed system, and included whether the resident's bed passed or failed all four zones of entrapment. During the inspection, residents were observed to be sleeping in 6 identified beds with one or both rails elevated (guard position). A review of the plan of care for the identified residents revealed that two had a notation that they were to have 2 bed rails up while in bed for safety, but no assessment identified exactly what the safety reasons were. The remaining four residents did not have any bed rail information identified in their plan of care. None of the residents had any documented assessments as to why bed rails were needed (repositioning, bed mobility, restraint etc) and whether other options were trialled before applying the bed rails.

Compliance Order #005 was previously issued for an inspection (2014-265526-0018) conducted between August 15-29, 2014 related to a lack of resident assessments to minimize risks to the resident where bed rails were used. The conditions laid out in the previous Order were not fully met during this inspection. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2015

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.

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 11th day of May, 2015

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : BERNADETTE SUSNIK

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