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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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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
Jan 4, 2017	2016_546585_0016	031670-16	Resident Quality Inspection

Licensee/Titulaire de permis

DELCARE LTC INC.
4800 DUFFERIN STREET TORONTO ON M3H 5S9

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

CAWTHRA GARDENS LIMITED PARTNERSHIP
590 Lolita Gardens MISSISSAUGA ON L5A 4N8

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

LEAH CURLE (585), BERNADETTE SUSNIK (120), YVONNE WALTON (169)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): November 9, 10, 14, 15, 16, 17, 21, 22, 24, 28, 2016.

In addition to the RQI, nine concurrent inspections were completed including: one follow-up log #022765-16 regarding s.15(1) bed systems, four Critical Incident System (CIS) log #017300-16, #020377-16 and #023350-16 and regarding abuse, #032690-16 regarding falls and four complaints log #007741-15 regarding abuse, #008544-16 regarding medications, #018233-16 and #007965-16 regarding resident care and services.

During the course of the inspection, the inspector(s) spoke with residents, families, registered staff, personal support workers (PSWs), the physiotherapist (PT), Food Services Manager (FSM), Registered Dietitian (RD), Environmental Services Supervisor (ESS), Assistant Director of Care (ADOC), Director of Care (DOC) and the Administrator.

During the course of the inspection, the inspector(s): toured the home, observed care and services provided to residents, measured air temperatures, reviewed relevant records which included, but not limited to: resident clinical health records, policies, logs, staff training records and investigation records.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

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

- **7 WN(s)**
- **2 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L’INSPECTION	INSPECTOR ID #/ NO DE L’INSPECTEUR
O.Reg 79/10 s. 15. (1)	CO #001	2016_189120_0037	120

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The home's policy, "Resident Falls - LTC-CA-WQ-200-07-08", revised May 2016, outlined strategies of actions and interventions that could be implemented to support safety.

On a specified date in November 2016, resident #014 fell, was transferred to hospital and diagnosed with an injury. Review of the resident's plan of care stated they were at risk for falls and identified a specified falls prevention intervention. Review of their clinical record, including the fall incident note and progress notes did not indicate whether the intervention was in place at the time of the fall. On a specified date in November 2016, interview with registered staff #114 reported that on the day of the fall, they assisted the resident, did not believe the resident had the specified falls prevention intervention nor did they describe that the intervention was in place. Interview with personal support worker (PSW) #107 and PSW #108 who observed the resident after the fall could not confirm whether the intervention was in place. Interview with Director of Care (DOC) confirmed the resident's falls prevention intervention should have been in place at the tim

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 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 where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident’s medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not,

why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's clinical assessment form and processes related to overall bed safety was reviewed and it was determined not to be fully developed in accordance with the Clinical Guidance document identified above.

The licensee's policy and procedure titled "Bed System Assessment" dated January 2016, required registered staff to assess residents for safe bed use by ensuring the bed is tested for entrapment risk and to complete a Bed System Assessment. Confirmation was made that all beds were evaluated for entrapment and where necessary, changes were made to ensure that all beds passed entrapment. However, the clinical assessment of residents regarding safe bed use was not fully developed or explained in the policy.

According to the DOC and a registered nurse, all residents received an assessment by registered staff (with input from other staff members such as the PSWs and physiotherapist) and their conclusions were documented a Bed System Assessment form. As a result, a reduction of bed rail use dropped approximately 30%. The form, when reviewed, included the names of the interdisciplinary team involved in the assessment, check boxes requiring the assessor to select the purpose of the device (whether a restraint or a Personal Assistance Services Device PASD), type of rail used, how many, alternatives that were trialled (options however did not include bed rail alternatives), falls history, resident bed mobility, history of injury related to bed rails, skin and pain issues, whether the bed passed or failed entrapment testing and whether the family or resident had a preference about using the bed rails. The form however was not specifically geared towards a resident's sleeping behaviours and risks associated with bed rail use, if applied. No guidance was provided to assist the assessor in making any decisions when check boxes were selected, whether the resident was at risk if bed rails were to be applied and what safe interventions or bed system modifications were made if the bed rails were considered unsafe.

According to the DOC however, a sleeping observation for each resident was implemented with the assistance of PSWs. A form titled Bed Mobility Monitoring Sheet was used for a five day period. New residents admitted after June 2016 were all observed without bed rails initially to determine need, followed by an observation period with bed rails. However, many residents who were admitted to the home prior to June

2016 were observed only with bed rails applied.

Three residents were randomly selected, all of whom were observed to either have one or more bed rails in use or had a written plan of care indicating that they required one or more bed rails as a PASD.

A) Resident #020, resident #021 and resident #022 had bed rails applied as per either the resident or SDM's request. An observation period without applying the bed rails was not conducted as all three residents were admitted to the home prior to June 2016 and bed rails were applied at the time of admission. All three residents had a sleep observation conducted by PSWs for five days with bed rails applied in September 2016. The purpose of the sleep observation, as per the HC Guideline, is to determine what entrapment or injury risks are likely to occur while the resident is sleeping and awake when a bed rail is applied. However, the sleep observation process and form developed did not clearly identify what the PSW should have been looking for when observing a resident in bed. The form included a column titled “Sleep Patterns” and included notations that the resident was awake or asleep. The “Behaviours” column had notations of “none” for all three residents. Behaviours would have included movements and actions related to a number of conditions that affect seniors. The “Bed Mobility” column included notations as to why the bed rail was used (repositioning or transfers) and number of staff that provided assistance but did not include how the resident moved while in bed.

B) The Bed System Assessment form which included a section where the assessor was to select what alternatives were trialled, did not adequately identify what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. The form included a section titled, "Alternatives" and listed nine check boxes to choose from; floor mats, bed alarm, scheduled toileting, increased supervision, hi/low bed, restorative care referral, decreased time in bed, call bell within reach and placing assistance devices within reach. Most of the alternatives listed were not alternatives to using a bed rail but were accessories used in conjunction with a bed rail. For resident #020, the “Alternatives” section was not completed. For the remaining two residents that had the “Alternatives” section completed, no details were provided as to what was implemented in place of the bed rails before they were applied and whether it was successful or not before deciding that a hard bed rail was the safest choice for the resident.

C) The questions included on the Bed System Assessment form did not include several

key questions related to whether rails were used in the past and why, previous sleeping habits and patterns, toileting habits, relevant medical diagnoses, cognitive status and risk factors such as involuntary or spasmodic body movements, medication use, and injury to self. The results of the sleep observation could not be incorporated as the information collected by the PSWs was incomplete and was therefore not useful in making a comprehensive decision related to bed rail safety. Once the assessor selected the appropriate boxes that were relevant to the resident, no further guidance was provided to decide whether the resident was at any risk for entrapment or injury if bed rails were to be applied. After reviewing the three assessments, it was difficult to determine what if any risks were associated with the residents’ bed rails. The conclusion selected for all three residents was a check box that stated what type of bed rails were used, what they were used for, who requested the rail and that verbal consent obtained as a PASD. No space was available on the form for the registered nurse (RN) conclusions based on the information gathered by the PSWs, physiotherapist and family members. According to the RN who completed the three assessments, the decision to apply the bed rails was geared towards the preference of the resident and/or SDM and not on the RN’s own professional conclusions. The RN's conclusions were not identified in any of the three assessments.

Both the DOC and RN who participated in the completion of the assessment forms reported that they continued to feel pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them and before a full assessment could be completed. Educational materials regarding bed safety and the role of family members in the participation of selecting appropriate medical devices for resident use had not been provided but were in development at the time of inspection. [s. 15. (1) (a)]

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 and ensuring that where bed rails are used, 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, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that strategies were developed and implemented to respond to the resident demonstrating responsive behaviours.

Review of resident #013's progress notes completed by registered staff and Point of Care (POC) documentation completed by PSWs revealed over ten occasions in August 2016 when they demonstrated inappropriate behaviours. Review of the resident's written plan of care did not include strategies to respond to the resident's responsive behaviours until a specified date in September 2016, which was confirmed by registered staff #113. [s. 53. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that for each resident demonstrating responsive behaviours, strategies are developed and implemented to respond to these behaviours, where possible, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or the Regulation required, any plan, policy, protocol, procedure, strategy or system in place was complied with.

The home's policy, "Medication Administration, LTC-CA-WQ-200-06-01", revised July 2015, directed staff to (i) observe the resident taking all of the medications with water provided - never leave medication at side of bed, on table in dining room, at resident's side - always ensure they take the medication. On a specified date in November 2016, during a medication pass, registered staff #100 administered medications to resident #004. The resident requested to take the medication with them to take at a later time. Registered staff #100 agreed to the resident's request and did not ensure the resident took their medication. Registered staff #100 confirmed the medication administration policy was not complied with. [s. 8. (1) (b)]

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that their written policy to promote zero tolerance of abuse and neglect of residents was complied with.

The home's policy, "Resident Abuse-Abuse Prevention Program - Whistle-blowing Protection", LTC-CA-WQ-100-05-02", revised October 2014, stated, "Physical abuse means any behaviour exhibited towards a resident, which is or may be perceived by the resident or may be perceived by the resident as physical force that may or does cause injury, or inflicts pain or discomfort for the resident. Abuse reporting is mandatory; all staff members are required to report any abuse, suspected abuse or allegation of abuse immediately, all provincial legislative reporting requirements will be followed."

On a specified date in April 2015, resident #018 was physically responsive toward resident #019 and as a result, resident #019 sustained an injury. Review of the home's Critical Incident Report (CI) revealed that the home did not submit the CI until four days later, as confirmed by the DOC. [s. 20. (1)]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the responsive behaviour plan of care was based on an interdisciplinary assessment of resident #012 that included: any mood and behaviour pattern, including wandering, any identified responsive behaviours any potential behavioural triggers and variations in resident functioning at different times of the day.

From their time of admission in 2015, resident #012 exhibited responsive behaviours; however, their plan of care did not identify the behaviours nor were there any interventions developed to manage the behaviours. From admission through to a specified date in August 2016, multiple progress notes the resident's clinical record indicated they exhibited responsive behaviours.

On a specified date in August 2016, a PSW was observed attempting to provide care to resident #012 while the resident demonstrated responsive behaviours. The resident sustained injuries from the PSW's efforts to provide care. There was no plan of care developed based on an interdisciplinary assessment of resident #012's history of behaviours. This was confirmed by lack of documentation and interviews with the Behaviour Support lead and the DOC. [s. 26. (3) 5.]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident’s written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was created and maintained for each resident of the home.

Review of resident #018's progress notes indicated a specified type of charting was in effect in April and May 2015. The DOC confirmed the charting was completed; however, was unable to locate the written record. [s. 231. (a)]

Issued on this 26th day of January, 2017

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LEAH CURLE (585), BERNADETTE SUSNIK (120), YVONNE WALTON (169)
Inspection No. / No de l'inspection :	2016_546585_0016
Log No. / Registre no:	031670-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 4, 2017
Licensee / Titulaire de permis :	DELCARE LTC INC. 4800 DUFFERIN STREET, TORONTO, ON, M3H-5S9
LTC Home / Foyer de SLD :	CAWTHRA GARDENS LIMITED PARTNERSHIP 590 Lolita Gardens, MISSISSAUGA, ON, L5A-4N8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Elizabeth Bryce

To DELCARE LTC INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

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

Order / Ordre :

A) The licensee shall ensure that the care set out in the plan of care is provided to all residents as specified in the plan, including resident #014, in relation to falls intervention strategies.
B) All direct care staff receive re-education, that shall include but is not limited to: ensuring that the care set out in the plan of care is provided to residents as specified in the plan regarding falls intervention strategies.
C) The home will develop and implement auditing and corrective action process to ensure that when any resident's plan of care identifies falls interventions, care set out in the plan of care is provided to the resident as specified in the plan.

Grounds / Motifs :

1. This non-compliance had a severity of "actual harm/risk", with a scope "isolated" and an ongoing history of noncompliance.

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

The home's policy, "Resident Falls - LTC-CA-WQ-200-07-08", revised May 2016, outlined strategies of actions and interventions that could be implemented to support safety.

On a specified date in November 2016, resident #014 fell, was transferred to hospital and diagnosed with an injury. Review of the resident's plan of care stated they were at risk for falls and identified a specified falls prevention intervention. Review of their clinical record, including the fall incident note and progress notes did not indicate whether the intervention was in place at the time of the fall. On a specified date in November 2016, interview with registered staff #114 reported that on the day of the fall, they assisted the resident, did not believe the resident had the specified falls prevention intervention nor did they describe that the intervention was in place. Interview with personal support worker (PSW) #107 and PSW #108 who observed the resident after the fall could not confirm whether the intervention was in place. Interview with Director of Care (DOC) confirmed the resident's falls prevention intervention should have been in place at the time of the fall. [s. 6. (7)] (585)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 17, 2017

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

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
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.

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
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 4th day of January, 2017

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Leah Curle

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