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**


**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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119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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119 rue King Ouest 11iém étage
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**Public Copy/Copie du public**

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Apr 3, 2017 | 2017_539120_0018 | 029006-16 | Follow up |

## Licensee/Titulaire de permis

DEVONSHIRE ERIN MILLS INC.
195 DUFFERIN AVENUE SUITE 800 LONDON ON N6A 1K7

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

ERIN MILLS LODGE NURSING HOME
2132 DUNDAS STREET WEST MISSISSAUGA ON L5K 2K7

## 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): March 13, 2017**

**An inspection (2016-467592-0007) was previously conducted May 10-June 7, 2016 and an order related to bed safety issued on August 2, 2016. For this follow up inspection, one of the conditions laid out in the order was not met related to resident clinical assessments. See below for further details.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care, Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSWs).**

**During the course of the inspection, the inspector toured the home, observed bed systems, reviewed bed entrapment audit results, resident bed safety assessments and bed safety policies and procedures.**

**The following Inspection Protocols were used during this inspection:**
**Safe and Secure Home**

**During the course of this inspection, Non-Compliances were issued.**
- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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. 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, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted between May 10 and June 7, 2016, and non-compliance was identified with this section. An order with multiple conditions was issued, one of which included the requirement to develop an interdisciplinary resident assessment to be used to assess all residents who had care directions for the use of bed rails in accordance with the "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 adopted by Health Canada).

For this follow up inspection, five residents (#102 to #106) were selected for review to determine whether they were assessed for bed rail safety in accordance with the clinical guidance document and if risks were identified, evaluated and mitigated if necessary. It was determined that the staff who participated in the assessments of the residents, where bed rails were used, did not complete or fully assess the residents in accordance with the directions as specified in the clinical guidance document. The number of forms and assessments identified during the inspection were many, as the home was transitioning between two different systems, both electronically and manually. The home was operating under a new owner and new forms and methods were being introduced.

The licensee's newest policy titled "Bed Entrapment & Bedrail Assessment`(Tab 06-02 published November 21, 2016) included a section related to resident bed safety assessments. The direction included residents to be assessed by a registered team

before bed rails were applied and at any time with a change in condition and when a change in bed rail use was required. In addition, residents were to be assessed for potential risk associated with using bed rails through observation and input from multiple shifts and the inter-professional team (which can include PSWs, Kinesiologist, Physiotherapist, etc). The direction was noted to be consistent with the clinical guidance document. The policy directed the team to use a form titled "Resident/Bedrail Assessment (RBA)" which included a check list (appendix C page 1) and a decision tree or an organizational flow diagram (appendix C page 2). The check list (and comments text boxes beside each point) included potential risks to consider such as "sleeping patterns, awake and in bed - movement patterns, medical diagnosis, medications, toileting habits, safety habits, personal expressions around bed use, health status and environmental factors". The flow diagram was to be used to determine how the bed rails would be used, if considered a personal assistive services device (PASD) or a restraint. At the end, the assessor was to determine if the bed rails were considered a "high, medium or low" risk and recommendations. Neither the two forms or the policy included any direction with respect to how long resident's would be observed in bed, if and what alternatives would be trialled before the application of any bed rails, what specific sleeping patterns, habits and behaviours associated with an increase in bed related injuries would be included in the observation period, where the observations would be documented and by whom and what the terms "high, medium or low risk" meant on the organizational flow diagram form.

The licensee's policy tilted "Restraint & PASD Procedures in LTC" (Tab 04-52) included direction that the "team" consider and evaluate alternatives to the use of a physical device (bed rail) in collaboration with the resident and/or SDM before considering the use of the device on the resident. The completed assessment was to be included in the resident's chart and was titled "Alternatives to PASD/Restraint Assessment (APRA)". The device could therefore be used if all of the criteria were met, alternatives considered and tried where appropriate. The policy did not include examples of any bed related safety risks associated with bed rail use. The APRA form included risk factors for consideration such as cognition, medical diagnosis, medication use, falls with injury, recent fracture, personal expressions, inappropriate mobility equipment and acute delirium. The APRA form included a second page to document what alternatives were trialled and the outcome but the questions on the form nor the policy included a time frame for the trial. The APRA form included some relevant alternatives to bed rails which included a raised edge mattress, bed alarms, medical, cognitive, environmental and functional approaches. According to the clinical guidance document, the use of "perimeter reminders" or "border definers" such as body pillow, cushions, bolsters(soft

rails), hand grips and various specific monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. Some of these particular accessories or modified equipment were not included as options in the policy to better guide RN decision making and were not available in the home for staff to trial (i.e. soft rails or bolsters).

PSWs, who were tasked at observing all residents while in bed, were required to document what they saw on a flow sheet titled "Daily Observation Sheet". It included whether the resident was sleeping, awake, calm, unusually restless and behaviours related to being awake such as wandering and aggression. A PSW explained that if a resident was found in an unsafe situation, such as on the floor or in an unusual position, the RN would be notified. The observation sheet did not include behaviours or patterns of sleep associated with the potential of increasing bed related injuries such as sleeping on edge of the bed, sleeping with feet or arms through the bed rail or on the bed rail, sleeping with feet or head off the bed, etc. The role of the PSW and their observations were not included in either of the above noted policies.

Resident #102 was not in bed at the time of observation but had a rotating assist rail on the left in the assist position. The rotating assist bed rail was removed on one side. The remaining bed rail was tested for function and was very loose and bowed out and away from the mattress. The condition of the bed rail increased the gap between the mattress and the bed rail, creating the potential for entrapment or injury. The condition of the bed rail was reported to the RN who reported it to the maintenance person. The bed rail was tightened within an hour. The resident was admitted in September 2016, and their chart did not include completed RBA or APRA forms and the RN confirmed they were missing. The resident's chart included a signed consent for the bed rail dated the same date as the admission date. Based on the document, it appeared that the resident was provided with a bed rail on the same date as admission. The resident's written plan of care confirmed that the resident used a bed rail to turn while in bed but needed encouragement to use it and required limited assistance with bed mobility from staff. The plan included that the resident had poor balance, a history of falling and a sleeping condition. One day following admission, an RN completed a "Safety Risk Assessment", which was a different form used by the home in the past. The form included relevant bed safety questions such as confusion, attempts to get out of bed, climb over rails, immobile, spontaneous movements, history of falls, if fallen from bed, entrapped, sustained bruising or lacerations from bed rails or use of antipsychotic drugs. The form included an alternatives section titled "Alternatives to Physical Restraint" but none of the options included soft bolsters or border definers as a replacement for hard bed rails.

Resident #103 was not observed in bed during the inspection, but the bed had both quarter length bed rails elevated. The resident was admitted in October 2010, and their chart did not include completed RBA or APRA forms and the RN confirmed they were missing. The resident received a new bed with different bed rails in February 2017, and a re-assessment was not completed. The resident's written plan of care included that the resident was independent with bed mobility and required one bed rail to assist with turning in bed.

Resident #104 was not observed in bed at the time of inspection, but the bed had both quarter length bed rails elevated. The resident's chart included RBA and APRA forms dated January 2017, and other forms from October 2014, that concluded that the resident required half length bed rails for bed mobility. The resident received a new bed system with shorter bed rails in February 2017, and was not re-assessed. The resident's written plan of care included cognitive impairment, poor balance, poor co-ordination, and a history of falling. No information was included about bed rail use.

Residents #105 and #106 were both observed in bed with both of their bed rails in use at the time of inspection. Resident #106 had both quarter length bed rails elevated and resident #105 had their right bed rail in the guard position and the left bed rail in the assist position. Both residents were admitted in March 2017. Neither resident had a completed RBA or APRA forms to determine if the bed rails were assessed as safe for the resident or if alternatives were trialled.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. [s. 15. (1) (a)]

***Additional Required Actions:***

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

**Issued on this 7th day of April, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**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) :** | BERNADETTE SUSNIK (120) |
| **Inspection No. / No de l'inspection :** | 2017_539120_0018 |
| **Log No. / Registre no:** | 029006-16 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Apr 3, 2017 |
| **Licensee / Titulaire de permis :** | DEVONSHIRE ERIN MILLS INC.<br>195 DUFFERIN AVENUE, SUITE 800, LONDON, ON, N6A-1K7 |
| **LTC Home / Foyer de SLD :** | ERIN MILLS LODGE NURSING HOME<br>2132 DUNDAS STREET WEST, MISSISSAUGA, ON, L5K-2K7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Mary Whalen |

To DEVONSHIRE ERIN MILLS INC., 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)

**Linked to Existing Order / Lien vers ordre existant:** 2016_467591_0007, CO #002;

**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 complete the following:

1. Amend the home's existing forms related to resident assessments and their bed systems to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) which is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time, to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
c. the resident while sleeping for a specific period of time, to establish safety

risks to the resident after a bed rail has been applied and deemed necessary where an alternative was not successful; and

2. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006" and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form(s) and document the assessed results and recommendations for each resident.

4. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form(s). Include in the written plan of care any necessary interventions that are required to mitigate any identified bed safety hazards.

5. Amend the existing policy tilted "Bed Entrapment & Bedrail Assessment'`(Tab 06-02 published November 21, 2016), related to the safe use of bed rails by residents so that it will guide an assessor in completing resident clinical assessments in accordance with the U.S. F.D.A's document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings". The policy shall include the following; role of the PSW, direction with respect to how long resident's will be observed in bed with and without bed rails applied, how long residents will be observed in bed with and without alternatives applied, what types of alternatives are available to replace hard bed rails, what specific sleeping patterns, habits and behaviours are associated with an increase in bed related injuries and would be included in the observation period, where the observations would be documented and by whom and what the terms "high, medium and low risk" means on the organizational flow diagram form.

**Grounds / Motifs :**

1. The licensee did not ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted between May 10 and June 7, 2016, and non-compliance was identified with this section. An order with multiple conditions was issued, one of which included the requirement to develop an interdisciplinary resident assessment to be used to assess all residents who had care directions for the use of bed rails in accordance with the "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 adopted by Health Canada).

For this follow up inspection, five residents (#102 to #106) were selected for review to determine whether they were assessed for bed rail safety in accordance with the clinical guidance document and if risks were identified, evaluated and mitigated if necessary. It was determined that the staff who participated in the assessments of the residents, where bed rails were used, did not complete or fully assess the residents in accordance with the directions as specified in the clinical guidance document. The number of forms and assessments identified during the inspection were many, as the home was transitioning between two different systems, both electronically and manually. The home was operating under a new owner and new forms and methods were being introduced.

The licensee's newest policy titled "Bed Entrapment & Bedrail Assessment`(Tab 06-02 published November 21, 2016) included a section related to resident bed safety assessments. The direction included residents to be assessed by a registered team before bed rails were applied and at any time with a change in condition and when a change in bed rail use was required. In addition, residents were to be assessed for potential risk associated with using bed rails through observation and input from multiple shifts and the inter-professional team (which can include PSWs, Kinesiologist, Physiotherapist, etc). The direction was noted to be consistent with the clinical guidance document. The policy directed the team to use a form titled "Resident/Bedrail Assessment (RBA)" which included a check list (appendix C page 1) and a decision tree or an organizational flow diagram (appendix C page 2). The check list (and comments text boxes beside each point) included potential risks to consider such as "sleeping patterns, awake and in bed - movement patterns, medical diagnosis, medications, toileting habits, safety habits, personal expressions around bed use, health status and environmental factors". The flow diagram was to be used to determine how the

bed rails would be used, if considered a personal assistive services device (PASD) or a restraint. At the end, the assessor was to determine if the bed rails were considered a "high, medium or low" risk and recommendations. Neither the two forms or the policy included any direction with respect to how long resident's would be observed in bed, if and what alternatives would be trialled before the application of any bed rails, what specific sleeping patterns, habits and behaviours associated with an increase in bed related injuries would be included in the observation period, where the observations would be documented and by whom and what the terms "high, medium or low risk" meant on the organizational flow diagram form.

The licensee's policy tilted "Restraint & PASD Procedures in LTC" (Tab 04-52) included direction that the "team" consider and evaluate alternatives to the use of a physical device (bed rail) in collaboration with the resident and/or SDM before considering the use of the device on the resident. The completed assessment was to be included in the resident's chart and was titled "Alternatives to PASD/Restraint Assessment (APRA)". The device could therefore be used if all of the criteria were met, alternatives considered and tried where appropriate. The policy did not include examples of any bed related safety risks associated with bed rail use. The APRA form included risk factors for consideration such as cognition, medical diagnosis, medication use, falls with injury, recent fracture, personal expressions, inappropriate mobility equipment and acute delirium. The APRA form included a second page to document what alternatives were trialled and the outcome but the questions on the form nor the policy included a time frame for the trial. The APRA form included some relevant alternatives to bed rails which included a raised edge mattress, bed alarms, medical, cognitive, environmental and functional approaches. According to the clinical guidance document, the use of “perimeter reminders” or “border definers” such as body pillow, cushions, bolsters(soft rails), hand grips and various specific monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. Some of these particular accessories or modified equipment were not included as options in the policy to better guide RN decision making and were not available in the home for staff to trial (i.e. soft rails or bolsters).

PSWs, who were tasked at observing all residents while in bed, were required to document what they saw on a flow sheet titled "Daily Observation Sheet". It included whether the resident was sleeping, awake, calm, unusually restless and behaviours related to being awake such as wandering and aggression. A PSW

explained that if a resident was found in an unsafe situation, such as on the floor or in an unusual position, the RN would be notified. The observation sheet did not include behaviours or patterns of sleep associated with the potential of increasing bed related injuries such as sleeping on edge of the bed, sleeping with feet or arms through the bed rail or on the bed rail, sleeping with feet or head off the bed, etc. The role of the PSW and their observations were not included in either of the above noted policies.

Resident #102 was not in bed at the time of observation but had a rotating assist rail on the left in the assist position. The rotating assist bed rail was removed on one side. The remaining bed rail was tested for function and was very loose and bowed out and away from the mattress. The condition of the bed rail increased the gap between the mattress and the bed rail, creating the potential for entrapment or injury. The condition of the bed rail was reported to the RN who reported it to the maintenance person. The bed rail was tightened within an hour. The resident was admitted in September 2016, and their chart did not include completed RBA or APRA forms and the RN confirmed they were missing. The resident's chart included a signed consent for the bed rail dated the same date as the admission date. Based on the document, it appeared that the resident was provided with a bed rail on the same date as admission. The resident's written plan of care confirmed that the resident used a bed rail to turn while in bed but needed encouragement to use it and required limited assistance with bed mobility from staff. The plan included that the resident had poor balance, a history of falling and a sleeping condition. One day following admission, an RN completed a "Safety Risk Assessment", which was a different form used by the home in the past. The form included relevant bed safety questions such as confusion, attempts to get out of bed, climb over rails, immobile, spontaneous movements, history of falls, if fallen from bed, entrapped, sustained bruising or lacerations from bed rails or use of antipsychotic drugs. The form included an alternatives section titled "Alternatives to Physical Restraint" but none of the options included soft bolsters or border definers as a replacement for hard bed rails.

Resident #103 was not observed in bed during the inspection, but the bed had both quarter length bed rails elevated. The resident was admitted in October 2010, and their chart did not include completed RBA or APRA forms and the RN confirmed they were missing. The resident received a new bed with different bed rails in February 2017, and a re-assessment was not completed. The resident's written plan of care included that the resident was independent with bed mobility

and required one bed rail to assist with turning in bed.

Resident #104 was not observed in bed at the time of inspection, but the bed had both quarter length bed rails elevated. The resident's chart included RBA and APRA forms dated January 2017, and other forms from October 2014, that concluded that the resident required half length bed rails for bed mobility. The resident received a new bed system with shorter bed rails in February 2017, and was not re-assessed. The resident's written plan of care included cognitive impairment, poor balance, poor co-ordination, and a history of falling. No information was included about bed rail use.

Residents #105 and #106 were both observed in bed with both of their bed rails in use at the time of inspection. Resident #106 had both quarter length bed rails elevated and resident #105 had their right bed rail in the guard position and the left bed rail in the assist position. Both residents were admitted in March 2017. Neither resident had a completed RBA or APRA forms to determine if the bed rails were assessed as safe for the resident or if alternatives were trialled.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

This order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s. 15(1) of Ontario Regulation 79/10, the scope of the non-compliance is widespread, as none of the residents who used one or more bed rails were assessed in accordance with prevailing practices, the severity of the non-compliance has the potential to cause harm to residents related to bed safety concerns and the history of non-compliance is on-going as an order was previously issued on August 2, 2016. (120)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 31, 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
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La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 3rd day of April, 2017**

**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