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 sions 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
Jul 25, 2017	2017_539120_0042	001089-17	Follow up

Licensee/Titulaire de permis

EXTENDICARE (CANADA) INC.
3000 STEELES AVENUE EAST SUITE 700 MARKHAM ON L3R 9W2

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

EXTENDICARE BRAMPTON
7891 Mclaughlin Road BRAMPTON ON L6Y 5H8

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): July 4, 2017

An inspection (2016-553536-0021) was previously conducted November 23 to December 6, 2016, and an order subsequently issued for failure to ensure residents who used bed rails were assessed in accordance with prevailing practices. For this follow up inspection, the order remains outstanding. See below for details.

During the course of the inspection, the inspector(s) spoke with the Director of Care, Clinical Lead, a Registered Practical Nurse, Personal Support Worker and a maintenance person.

During the course of the inspection, the inspector toured 4 home areas, reviewed resident clinical bed safety assessments, bed safety policies and procedures and bed entrapment audit results.

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 WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 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.

The prevailing practice identified as 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) was identified by the Ministry of Health and Long Term Care in 2012, and provides the necessary guidance in establishing a clinical assessment where bed rails are used.

An inspection (2016-553536-0021) was previously conducted November 23 to December 6, 2016, and non-compliance was identified with this section related to resident clinical assessments where residents used bed rails. An order with multiple conditions was issued on December 14, 2016, for a compliance date of March 15, 2017. The order included requirements to (1) review and revise the home's Bed Entrapment and Proper use of Bedrail Devices (08-10-01, April, 2011), (2) conduct a resident needs assessment for the use of bed rails to determine whether bed rails are to be used and which bed rail system is most appropriate, (3) conduct Bed Rail Risk Assessments for each resident who used bed rails to minimize the risk of entrapment, (4) take steps to minimize the risk of entrapment when bed rails are used, including when the resident uses an air mattress (5) evaluate the effectiveness of the home's Bed Entrapment and Proper Use of Bed Rail Devices policy and (6) train all direct care staff in the home regarding the home's Bed Entrapment and Proper Use of Bed Rail Devices Policy. During this follow up inspection, all residents were assessed for bed rail use, but the assessment did not include a risk

component and the process was determined to not be fully developed in accordance with the Clinical Guidance document identified above.

Seven residents (#101-107) were randomly selected during this inspection to determine if they were assessed for bed safety risks when bed rails were applied. Six out of the seven residents were all assessed on January 27, 2017, without adequate documentation made by an interdisciplinary team to determine what alternatives were trialled before applying one or more bed rails, the time frames the alternatives were trialled and whether they were successful or not and whether the bed rails being used by the residents posed any identified risks and if so, what interventions were implemented to mitigate those risks.

The home's policy, titled "Bedrail Minimization and Risk Reduction" (RC-10-01-10) included the requirement for registered staff to complete a form titled "Bedrail and Entrapment Risk Assessment" and to "assess the resident's situation looking for possible risk factors related to the use of bed rails". No guidance was included as to what type of risk factors staff were to be aware of and when the resident would need to be monitored and for how long. The policy also included a statement that "all alternative measures to promote resident safety must be assessed and considered prior to the use of bed rails". The policy did not include any guidance as to what alternative measures should be considered prior to the use of bed rails. The policy identified that the RN or RPN would "assess the continued need for bed rails post hospital discharge, upon any change in condition that impacts the continued need for bed rails and at a minimum quarterly". Six out of the seven above noted residents who were assessed for bed rails in January 2017, were not re-assessed in March or April 2017.

The above noted seven residents were not assessed using the "Bedrail and Entrapment Risk Assessment" form, but a different form titled "Bed Rail Risk Assessment" form (BRRA). Some differences were noted between the two forms, especially related to risk related questions. Neither form included information about the alternatives trialled but instead a check box was made available which stated "alternatives to siderails discussed and included on plan of care".

A RPN who had conducted many of the resident assessments confirmed that their focus was on whether the resident could use the bed rail, either for turning or repositioning or if it was considered a restraint and therefore needed to be monitored. The focus did not include the identification and subsequent monitoring or mitigation of specific bed associated risk factors that would have increased the resident's chances of becoming

injured in and around the bed rail, becoming entrapped between the bed rail and the mattress, being suspended from the bed rail or from being partially suspended from the edge of the bed with body parts trapped behind a bed rail located centrally along the bed. The BRRA form included only two questions about the resident; whether the resident was at risk of falling out of bed; or if the resident used bed rails for positioning. Once answered, the RN identified on the form whether the resident would or would not have bed rails applied, how many, on what side and in some cases, would identify why (whether for bed mobility or a transfer aid).

Although the RPN considered and documented elsewhere in the resident's clinical record, some of the risk factors associated with safe bed rail use, such as the resident's overall physical condition, bed mobility, medication use, continence, cognition and history of falls, the RPN did not consider assessing the resident while asleep for various behaviours, actions or conditions that would impact their safety while in bed with one or more bed rails applied. Discussions held with the personal support workers revealed that they often informed the registered staff of resident behaviours during different times of the day, but no specific guidance had been provided to them that outlined the specific behaviours, conditions or actions they should be aware of with respect to bed related injury risks.

A) Resident #101 was admitted in 2017, and assessed on the same date, before the resident could be observed sleeping in bed. The RPN concluded that the resident did not require bed rails. The resident's most recent written plan of care however, identified that both quarter length bed rails were to be provided for bed mobility. During the inspection, the resident's bed, although unoccupied at the time of the visit, included two quarter length bed rails in the raised position (fully engaged). No information was documented about the resident's risk factors for potential injury, entrapment or suspension or what alternatives were trialled before employing the bed rails.

B) Resident #103 was admitted to the home in late 2013 and their BRRA was completed on January 27, 2017. The BRRA included information that the resident did not need the bed rails for positioning but was at risk of rolling out of bed. The resident's most recent written plan of care included that the resident will use two padded quarter side rails for safety. It also included a statement that staff were to cue/supervise resident to turn and reposition and that the bed was to be in the lowest position. During the inspection, the resident was observed in bed with both rotating assist rails in the "guard" position (horizontal along the centre of the bed) and the bed was elevated quite high, waist level. No information was documented about the resident's risk factors for potential injury,

entrapment or suspension related to their bed rails or what alternatives were trialled before employing the bed rails. No re-assessments were available for review since January 27, 2017.

C) Resident #105 was admitted in mid-2016 and their BRRA was completed on January 27, 2017. The BRRA included information that the resident did not need the bed rails for positioning and was not at risk of rolling out of bed. The resident's written plan of care however included that the resident required a quarter side rail, could grab it and pull themselves up to assist with repositioning. It also included a statement that "bedrails secured down". The RPN explained that bed rails that were secured down meant that they were “tied down” to the frame so that they could not be used. During the inspection, the resident was observed in bed with both quarter length bed rails elevated or raised and was provided with a therapeutic air mattress. According to the maintenance person, the mattress had not been evaluated for entrapment concerns as the mattress was too soft and he therefore did not document that the bed failed entrapment zones 2 to 4. In such a case, the registered staff would have been responsible for ensuring that the bed rails did not pose entrapment hazards for the resident while in bed and would need to determine if the bed rails were a safe alternative for the resident. No information was documented about what interventions were in place to mitigate any potential risks and no information was available about the resident's risk factors for potential injury, entrapment or suspension related to their bed. No re-assessment was completed by registered staff since January 27, 2017.

D) Resident #106 was admitted in late 2015, and their BRRA was completed on January 27, 2017. The BRRA included information that the resident did not need the bed rails for positioning and was not at risk of rolling out of bed. The resident's written plan of care however included that they required one bed rail on the right for transfers and positioning. The resident was assessed with an identified disorder, risk of falling, wandering behaviour and medication use that could cause confusion. No information was documented about the resident's risk factors for potential injury, entrapment or suspension related to these conditions or what alternatives were trialled before employing the bed rails. No re-assessment was completed by registered staff since January 27, 2017.

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 non-compliance 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 pattern, as more than one of the residents who used one or more bed rails was not 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 December 14, 2016. [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 3rd day of August, 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 sions 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_0042
Log No. / Registre no:	001089-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jul 25, 2017
Licensee / Titulaire de permis :	EXTENDICARE (CANADA) INC. 3000 STEELES AVENUE EAST, SUITE 700, MARKHAM, ON, L3R-9W2
LTC Home / Foyer de SLD :	EXTENDICARE BRAMPTON 7891 Mclaughlin Road, BRAMPTON, ON, L6Y-5H8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Ptacek

To EXTENDICARE (CANADA) 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)

Linked to Existing Order / Lien vers ordre existant: 2016_553536_0021, 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 clinical 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 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

c. 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.

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. Amend the current "Bedrail Minimization and Risk Reduction" policy (RC-10-01-10) to include additional and relevant information noted in the prevailing practices identified as 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) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards” related to the identification of risk factors associated with bed rail use. At a minimum the policy shall include;
a) details of the process of assessing residents upon admission, when a change in the resident's condition has been identified and at an established frequency to monitor residents for risks associated with bed rail use on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents.
c) alternatives available for the replacement of bed rails; and
d) interventions available to mitigate any identified bed safety risks (i.e. wedges, bolsters, bed rail pads); and
f) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility; and
g) additional information on the role and responsibilities of the personal support worker who is involved in observing residents for risks related to the use of one or more bed rails.

4. All direct care staff are to be informed about the amended bed rail

minimization policy and be provided with face to face education about bed entrapment zones, the current laws related to bed systems in Ontario, resident risk factors that are considered high risk for bed system injury or entrapment, the available accessories and options used to mitigate bed system injuries and entrapment, the benefits versus the risks of bed rail use, alternatives to bed rail use and how to identify bed rails or other bed system components that are not in good working order and the process of reporting and mitigating any malfunctions.

5. Update the written plan of care for those residents where changes were identified after re-assessing each resident who uses one or more bed rails, using the amended resident clinical assessment form and/or process related to bed systems. Include in the written plan of care any necessary accessories or interventions that were required to mitigate any identified bed safety hazards, the type and size of the bed rail, why it is being used, when it is to be used, how many bed rails are to be applied and on what side of the bed.

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.

The prevailing practice identified as 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) was identified by the Ministry of Health and Long Term Care in 2012, and provides the necessary guidance in establishing a clinical assessment where bed rails are used.

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entrapment when bed rails are used, including when the resident uses an air mattress (5) evaluate the effectiveness of the home's Bed Entrapment and Proper Use of Bed Rail Devices policy and (6) train all direct care staff in the home regarding the home's Bed Entrapment and Proper Use of Bed Rail Devices Policy. During this follow up inspection, all residents were assessed for bed rail use, but the assessment did not include a risk component and the process was determined to not be fully developed in accordance with the Clinical Guidance document identified above.

Seven residents (#101-107) were randomly selected during this inspection to determine if they were assessed for bed safety risks when bed rails were applied. Six out of the seven residents were all assessed on January 27, 2017, without adequate documentation made by an interdisciplinary team to determine what alternatives were trialled before applying one or more bed rails, the time frames the alternatives were trialled and whether they were successful or not and whether the bed rails being used by the residents posed any identified risks and if so, what interventions were implemented to mitigate those risks.

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available which stated "alternatives to siderails discussed and included on plan of care".

A RPN who had conducted many of the resident assessments confirmed that their focus was on whether the resident could use the bed rail, either for turning or repositioning or if it was considered a restraint and therefore needed to be monitored. The focus did not include the identification and subsequent monitoring or mitigation of specific bed associated risk factors that would have increased the resident's chances of becoming injured in and around the bed rail, becoming entrapped between the bed rail and the mattress, being suspended from the bed rail or from being partially suspended from the edge of the bed with body parts trapped behind a bed rail located centrally along the bed. The BRRA form included only two questions about the resident; whether the resident was at risk of falling out of bed; or if the resident used bed rails for positioning. Once answered, the RN identified on the form whether the resident would or would not have bed rails applied, how many, on what side and in some cases, would identify why (whether for bed mobility or a transfer aid).

Although the RPN considered and documented elsewhere in the resident's clinical record, some of the risk factors associated with safe bed rail use, such as the resident's overall physical condition, bed mobility, medication use, continence, cognition and history of falls, the RPN did not consider assessing the resident while asleep for various behaviours, actions or conditions that would impact their safety while in bed with one or more bed rails applied. Discussions held with the personal support workers revealed that they often informed the registered staff of resident behaviours during different times of the day, but no specific guidance had been provided to them that outlined the specific behaviours, conditions or actions they should be aware of with respect to bed related injury risks.

A) Resident #101 was admitted in 2017, and assessed on the same date, before the resident could be observed sleeping in bed. The RPN concluded that the resident did not require bed rails. The resident's most recent written plan of care however, identified that both quarter length bed rails were to be provided for bed mobility. During the inspection, the resident's bed, although unoccupied at the time of the visit, included two quarter length bed rails in the raised position (fully engaged). No information was documented about the resident's risk factors for potential injury, entrapment or suspension or what alternatives were trialled before employing the bed rails.

B) Resident #103 was admitted to the home in late 2013 and their BRRA was completed on January 27, 2017. The BRRA included information that the resident did not need the bed rails for positioning but was at risk of rolling out of bed. The resident's most recent written plan of care included that the resident will use two padded quarter side rails for safety. It also included a statement that staff were to cue/supervise resident to turn and reposition and that the bed was to be in the lowest position. During the inspection, the resident was observed in bed with both rotating assist rails in the "guard" position (horizontal along the centre of the bed) and the bed was elevated quite high, waist level. No information was documented about the resident's risk factors for potential injury, entrapment or suspension related to their bed rails or what alternatives were trialled before employing the bed rails. No re-assessments were available for review since January 27, 2017.

C) Resident #105 was admitted in mid-2016 and their BRRA was completed on January 27, 2017. The BRRA included information that the resident did not need the bed rails for positioning and was not at risk of rolling out of bed. The resident's written plan of care however included that the resident required a quarter side rail, could grab it and pull themselves up to assist with repositioning. It also included a statement that "bedrails secured down". The RPN explained that bed rails that were secured down meant that they were “tied down” to the frame so that they could not be used. During the inspection, the resident was observed in bed with both quarter length bed rails elevated or raised and was provided with a therapeutic air mattress. According to the maintenance person, the mattress had not been evaluated for entrapment concerns as the mattress was too soft and he therefore did not document that the bed failed entrapment zones 2 to 4. In such a case, the registered staff would have been responsible for ensuring that the bed rails did not pose entrapment hazards for the resident while in bed and would need to determine if the bed rails were a safe alternative for the resident. No information was documented about what interventions were in place to mitigate any potential risks and no information was available about the resident's risk factors for potential injury, entrapment or suspension related to their bed. No re-assessment was completed by registered staff since January 27, 2017.

D) Resident #106 was admitted in late 2015, and their BRRA was completed on January 27, 2017. The BRRA included information that the resident did not need the bed rails for positioning and was not at risk of rolling out of bed. The

resident's written plan of care however included that they required one bed rail on the right for transfers and positioning. The resident was assessed with an identified disorder, risk of falling, wandering behaviour and medication use that could cause confusion. No information was documented about the resident's risk factors for potential injury, entrapment or suspension related to these conditions or what alternatives were trialled before employing the bed rails. No re-assessment was completed by registered staff since January 27, 2017.

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 non-compliance 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 pattern, as more than one of the residents who used one or more bed rails was not 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 December 14, 2016. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 29, 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
TORONTO, 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
TORONTO, 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 25th day of July, 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