Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 7, 2020	2019_603194_0028	013008-19, 019480-19, 020753-19, 022268-19	Critical Incident System

Licensee/Titulaire de permis

The Corporation of the City of Peterborough and The Corporation of the County of Peterborough
c/o Fairhaven 881 Dutton Road PETERBOROUGH ON K9H 7S4

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

Fairhaven
881 Dutton Road PETERBOROUGH ON K9H 7S4

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

CHANTAL LAFRENIERE (194), KARYN WOOD (601)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): November 14, 15, 18, 19, 20, 25, 26, 27 and December 3, 2019

During the inspection the following critical incident logs were inspected;
an incident related to a fall.
an incident related to abuse.
an incident related to care of a resident.
an incident related to bed entrapment.

During the course of the inspection, the inspector(s) spoke with Residents, Executive Director (ED), Director of Care (DOC), Resident Care Manager (RCM), Resident Care Supervisor (RCS), Physio Therapist (PT), Environmental Services Manager (ESM), Registered Nurse (RN), Registered Practical Nurse (RPN) and Personal Support Worker (PSW).

Reviewed clinical health records of identified residents, internal abuse investigation, relevant policies; "Bed safety - prevention of entrapment", "Falls prevention" and "Restraint Minimization", observed staff to resident provision of care and resident's bed system.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Minimizing of Restraining
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.
- **2 WN(s)**
- **1 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	Légende 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 has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices to minimize the risk to resident.

A Critical Incident Report (CIR) was submitted to the director reporting an incident of bed rail entrapment involving resident #009. The CIR described that on an identified date, PSW staff had repositioned resident #009 after being assisted to bed. PSW #134 found resident #009 entrapped in the bed system and RPN #137 was notified. RPN #137 assessed resident #009 to have an injury. RPN #133 and RN #131 later assessed resident #009 and documented further injury.

During an interview with Inspector #194, ESM #132 indicated that the home completed their "Entrapment Bed Audit" every two years. ESM #132 indicated during interview that the home had completed it's last Entrapment Bed Audit, stating that none of the beds in the home had failed any of the entrapment zone areas. ESM #132 indicated that when mattress were changed on the beds, the bed system was not re-evaluated, as the home ordered the exact same mattress for all of the beds.

During an interview with Inspector #194, Executive Director indicated that the home had completed its Entrapment Bed Audit for the home, although was unable to provide evidence of the Entrapment Bed Audit, during the inspection.

During an interview with Inspector #194, DOC indicated that the home had not been completing Bed Rail assessments for residents who had bed rails in use in the home,

prior to the entrapment incident involving resident #009.

Resident #009 is described in the plan of care as being independent with use of mobility device, requiring two staff assist with transfer, toileting and was at high risk for falls.

Inspector #194 reviewed the licensee's internal investigation and interviewed PSW and RPN's involved in the bed rail entrapment incident involving resident #009.

During interview with Inspector #194, resident #009 indicated they recalled the incident, stating that they had fallen out of the bed. All staff interviewed indicated that resident #009 became entrapped in the bed system resulting in injury, but did not fall out of bed.

Observation of resident #009's bed system, indicated that there were two half bed rails in the upright position, with a specialized mattress to minimize falls.

Review of the resident's clinical health record and interview with PSW and registered staff indicated that resident #009 had a history of becoming entrapped in the bed system. Resident #009's symptoms increased the resident's risk for entrapment in the bed system. No bed rail assessment for resident #009 had been completed and the bed system had not been re-evaluated for entrapment zones when a new mattress was applied.

Inspector #194 increased the scope of resident's related to bed entrapment and included resident #010, #012 and #013.

Resident #010 was described in the plan of care as requiring total care for all ADL's, requiring two staff assist for transfer, toileting, was at high risk for falls and dependent with use of mobility device with restraint. The plan of care indicated that resident #010 was to have one full bed rail for positioning and used a bed rail pad.

Observation of resident #010's bed system was completed by Inspector #194, it was noted that the bed system, had two half bed rails in place, both covered in padding.

The clinical health record for resident #010 did not accurately identify the type of bed rails in use and did not include a bed rail assessment completed for the use of the bed rail.

Resident #012 was described in the plan of care as being independent with mobility aid, requiring two staff assist with transfer, toileting and at moderate risk for falls. The plan of

care did not identify any use of bed rails for the resident

Observation of resident #012's bed system indicated, two full bed rails on the bed, with one bed rail up, and the other in the down position.

Interview with resident #012 was completed by Inspector #194 related to the use of the bed rails. Resident #012 was able to verify that staff applied, one full rail when resident was in bed.

The clinical health record for resident #012 did not identify any bed rails in use and did not include a bed rail assessment completed for the use of the bed rails.

Resident #013's plan of care described the resident as being dependent on staff for mobility in mobility device, requiring two staff assist with all ADL's, transferring and toileting. The plan of care did not identify any use of bed rails or specialized mattress in use for resident #013.

Resident #013's bed system was observed to have a specialized mattress on the bed with one full bed rail up and one full bed rail down.

During an interview with Inspector #194, PSW #139 described resident #013's bed system as having a specialized mattress, one full rail up and one full rail down.

During an interview with Inspector #194, resident #013 indicated that one full bed rail was up, when in bed. Resident #013 indicated that they preferred the bed rail up for mobility.

The licensee failed to provide evidence that bed system evaluations or that bed rail assessments were completed for resident #009, #010, #012 and #013. Resident #009 was involved in a bed rail entrapment resulting in injury, resident #010's clinical health record did not identify the proper bed rails in use, resident #012's clinical health record did not identify any bed rails that were in use, resident #013 clinical health record did not identify any use of bed rails or use of specialty mattress, at the time of the inspection. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 has failed to ensure that resident 005's care set out in the plan of care was provided to the resident as specified in the plan related to continence and falls prevention.

A CIR was submitted to the Director related to an incident involving resident #005. According to the CIR, PSW #121 and PSW #120 assisted resident #005 with continence care. PSW #121 informed PSW #122 that resident #005 was being provided continence care, prior to leaving the unit.The CIR further indicated resident #005 was assessed with an injury the following day.

A review of resident #005's clinical health record identified, mobility was impaired with an unsteady gait and resident was at a moderate risk for falls.

Review of resident #005's care plan for continence, included two staff assist with device and total assistance for the entire process. Resident #005's care plan for falls, included having call bell within reach and checked every hour to ensure safety.

During separate interviews PSW #123, PSW #129, PSW #130 and RCM #103 indicated that resident #005's care plan interventions for continence and falls prevention included hourly safety checks, call bell within reach and to remain with resident during the entire process for continence care.

During a telephone interview, PSW #121 indicated that they and PSW #120 had assisted resident #005 for continence care and had left the resident unattended. PSW #121

indicated that they could not recall if the resident was provided the call bell. PSW #121 further indicated they did not complete resident #005's hourly safety checks.

During a telephone interview, PSW #123 indicated they had not completed the hourly safety check when they started their shift. PSW #123 indicated resident #005 did not have their call bell within reach when resident #005 was checked.

During an interview, RCM #103 indicated the outcome of the internal investigation determined that resident #005 had been left unattended during continence care. RCM #103 further indicated the PSWs, had not completed resident #005's hourly safety checks and the resident was not provided with the call bell, as specified in the resident's plan of care.

The licensee did not ensure that resident 005's care set out in the plan of care was provided as specified related to hourly checks, provision of the call bell and staff to remain with resident during continence care. [s. 6. (7)]

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 by ensuring that the care set out for resident #005 related to toileting and falls prevention is provided as specified in the plan of care, to be implemented voluntarily.

Issued on this 13th day of January, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Licensee Copy/Copie du rapport du titulaire de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CHANTAL LAFRENIERE (194), KARYN WOOD (601)
Inspection No. / No de l'inspection :	2019_603194_0028
Log No. / No de registre :	013008-19, 019480-19, 020753-19, 022268-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jan 7, 2020
Licensee / Titulaire de permis :	The Corporation of the City of Peterborough and The Corporation of the County of Peterborough c/o Fairhaven, 881 Dutton Road, PETERBOROUGH, ON, K9H-7S4
LTC Home / Foyer de SLD :	Fairhaven 881 Dutton Road, PETERBOROUGH, ON, K9H-7S4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lionel Towns

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To The Corporation of the City of Peterborough and The Corporation of the County of Peterborough, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Order # / No d'ordre : 001

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

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 must be compliant with O. Reg. 79/10, s. 15 (1) (a)

Specifically the licensee must:

1. Immediately begin the process of evaluating all bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). In consideration of rotating assist rails, intermediate locking and stopping positions are to be evaluated, as well as the use of air mattress surfaces in the home.

2. Take immediate corrective action should any bed system not meet dimensional guidelines outlined in the HC guidance document.
Consider the information outlined in the prevailing practices document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (FDA,2006).

3. Maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident and which reflects the most recent evaluation for each bed system. Ensure that a re-evaluation of a bed systems is completed as required, such as when a new bed system is

created as a result of a change or replacement of components.

4. Ensure that bed rail use, or removal from use, for residents #009, #010 and #012, #013 and any other resident, is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003)". This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, or interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower than that of other interventions or of not using them.

c) Where bed rails are in use, approval of the use of bed rails for an individual resident by the interdisciplinary team members that conducted the resident's assessment and produced the subsequent risk benefit assessment. The names of the team members, and their approval, is to be clearly documented.

5. Update the written plan of care based on the resident's assessment/reassessment by the interdisciplinary team. When bed rails are in use, provide clear direction as to what position bed rails are to be used in and when. Include in the written plan of care any necessary accessories or

interventions that are required to mitigate any identified bed safety hazards resulting from the bed system evaluations.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices to minimize the risk to resident.

On November 20, 2019, a Critical Incident Report (CIR) was submitted to the director reporting an incident of bed rail entrapment involving resident #009. The CIR described that on the evening of November 19, 2019, PSW staff had repositioned resident #009 several times after being assisted to bed. At 2200 hours, PSW #134 found resident #009 with their right leg through the bed rail and RPN #137 was notified. RPN #137 assessed resident #009 to have a reddened right knee with an indent from the bed rail, but no broken skin. At 0435 RPN #133 assessed resident #009 and documented an abrasion and broken skin to the resident's right knee, with bruising and redness surrounding the knee. On November 20, 2019, RN #131 assessed the resident's right leg and also noted bruising and redness to bridge of the resident's nose and bruising to the resident's left shoulder as well as a small bump on the back of the resident's head by their left ear.

During an interview with Inspector #194, ESM #132 indicated that the home completed their "Entrapment Bed Audit" every two years and were scheduled to complete the next Entrapment Bed Audit, in December 2019. ESM #132 indicated during interview that the home had completed it's last Entrapment Bed Audit in 2017, stating that none of the bed in the home had failed any of the entrapment zone areas. ESM #132 indicated to inspector #194 that the home did not replace bed rails in the home, that if a specific bed rail was required for a resident, the entire bed system would be changed, providing the resident with entirely new bed system with the proper bed rails. ESM #132 indicated that when mattress were changed on the beds, the bed system was not retested, as the home ordered the exact same mattress for all of the beds.

During an interview with Inspector #194, Executive Director indicated that the home had completed its 2017 Entrapment Bed Audit for the home although was unable to provide evidence of the Entrapment Bed Audit, during the inspection.

During an interview with Inspector #194, DOC indicated that the home had not been completing Bed Rail assessments for residents who had bed rails in use in the home, prior to the entrapment incident on November 19, 2019, involving resident #009.

Resident #009 is described in the plan of care as using a wheelchair for mobility and able to foot propel the chair, resident #009 required two staff assist with transfer and toileting was incontinent of bowel and bladder and at high risk for falls. Resident #009 was diagnosed with anxiety and Parkinson.

Inspector #194 reviewed the licensee's internal investigation and interviewed PSW and RPN's involved in the bed rail entrapment incident involving resident #009 on November 19 and 20, 2019.

During interview with Inspector #194, resident #009 described what they recalled of the incident on November 19, 2019. Resident #009 recalled the incident, stating that they had fallen out of the bed. All staff interviewed indicated that on November 19, 2019, resident #009's leg became trapped in the resident's bed rail resulting in injury, but did not fall out of bed.

Observation of resident #009's bed system on November 25, 2019, indicated that there were two half rails attached to the bed, which were locked in the upright position. The residents had an anti-roll mattress in place, with bolstered areas at the head and foot of the mattress to prevent residents from rolling out of bed.

Review of the resident's clinical health record and interview with PSW and registered staff indicated that resident #009 had a history of being found sideways in the bed and/or becoming trapped in the bed rails. Resident #009 diagnosis of Parkinson resulting in extreme involuntary movement of their limbs at unpredictable times were factors that would increase the resident's risk for entrapment in the bed rails. No bed rail assessment for resident #009 had been completed and the bed system had not been evalutated for entrapment zones when the new anti-roll mattress was applied.

Inspector #194 increased the scope of resident's related to bed rails and

included resident #010, #012 and #013.

Resident #010 was described in the plan of care as being cognitively impaired, requiring total care for all ADL's, requiring two staff assist for transfer and toileting as resident would not stay still, requiring constant supervision and physical assist for safety. Resident was able to weight bear, was at high risk for falls, related to non compliance with mobility aide and was unsteady. Resident #010 was dependent on wheelchair for mobility with use of seat belt. The plan of care indicated that resident #010 was to have one full bed rail for positioning and used a bed rail pad.

Observation of resident #010's bed system in room W536 was completed by Inspector #194, it was noted that the bed system, had two half rails in place, one down and one up, both covered in padding.

The clinical health record for resident #010 did not accurately identify the type of bed rails in use and did not include a bed rail assessment completed for the use of the bed rail.

Resident #012 was described in the plan of care with hypertension, and generalized osteoarthritis. The plan of care does not identify any use of bed rails for the resident. The plan of care indicated that resident #012 required two staff assist with transfer and toileting, being incontinent of bowel and bladder. Resident #012 was wheelchair dependent, encouraged to foot propel and was a moderate risk for falls, related to impaired mobility due to decreased strength and unsteady gait.

Observation of resident #012's bed system in room W554 was completed by Inspector #194, it was noted that the bed system, had two full bed rails on the bed, with one bed rail up, and the other in the down position, no padding was noted on the bed rails.

Interview with resident #012 was completed by Inspector #194 related to the use of the bed rails. Resident #012 was able to verify that staff applied, one full rail when resident was in bed. Resident #012 was noted with weakness in the right arm, which the resident was able to raise with assistance of the left hand. Resident #012 was able to foot propel the wheelchair.

The clinical health record for resident #012 did not identify any bed rails in use and did not include a bed rail assessment completed for the use of the bed rails.

Resident #013's plan of care described the resident as requiring two staff assist with all ADL's, transferring and toileting, being incontinent of both bowel and bladder and wheelchair dependent with staff assistance for mobility. The plan of care did not identify any use of bed rails or air mattress in use for resident #013.

Resident #013's bed system was observed by Inspector #194 to have an air mattress on the bed with one full bed rail up and one full bed rail down.

During an interview with Inspector #194, PSW #139 described resident #013's bed system as having an air mattress, one full rail up and one full rail down with no padding on the bed rails. PSW #139 indicated that resident #013 would use the call bell for assistance and did not self transfer, resident #013 was described as not being at risk for falls. PSW #139 indicated that resident #013 could be found, on the bed, at time leaning towards the bed rails in the morning on their affected right side (Stroke).

During an interview with Inspector #194, resident #013 indicated that one full bed rail near the wall was up, when they are in bed. Resident #013 indicated that they did not get caught in the bed rail while in the bed. Resident #013 indicated that they used the call bell to reach staff when required and that staff were quick to respond. Resident #013 indicated that they preferred the bed rail up near the wall stating it helped them from rolling out of bed and assisted with movement while they were on the bed.

The licensee failed to provide evidence that bed system evaluations or that bed rail assessments were completed for resident #009, #010, #012 and #013. Resident #009 was involved in a bed rail entrapment on November 19, 2019, resulting in injury, resident #010's clinical health record did not identify the proper bed rails in use, resident #012's clinical health record did not identify any bed rails that were in place, resident #013 clinical health record did not identify any use of bed rails or air mattress, at the time of the inspection.

The decision to issue a Compliance Order was based on the following; The

severity of this issue was determined to be a level 3 with actual harm to resident. The scope of the issue was a level 3 determined as widespread. The compliance history indicated that no previous non compliance to the section had been issued to the home. (194)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2020

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, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, 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
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 7th day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Chantal Lafreniere

Service Area Office /
Bureau régional de services : Central East Service Area Office