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 prévue le Loi de 2007 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
May 23, 2017;	2017_582548_0005 (A1)	020977-16, 022883-16, 029540-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner
2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

RUZICA SUBOTIC-HOWELL (548) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This Compliance order #001 due date was changed from June 2, 2017 to June 19, 2017. The Administrator approached Inspector #548 requesting an extension. A letter was forwarded on May 15, 2017 to Inspector #548 describing the work conducted to date, staff availability and outlined the remaining tasks the Licensee planned to complete.

Issued on this 23 day of May 2017 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 23, 2017;	2017_582548_0005 (A1)	020977-16, 022883-16, 029540-16	Critical Incident System

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner
2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

GARDEN TERRACE
100 Aird Place KANATA ON K2L 4H8

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

RUZICA SUBOTIC-HOWELL (548) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): March 27, 28 and 29, 2017. Offsite on April 21, 2017.

During the course of inspection the inspector observed the resident and the resident's bed system, reviewed the health care records and bed system evaluation documents.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Clinical Care Coordinator, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Maintenance manager and family member.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Hospitalization and Change in Condition

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Responsive Behaviours

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 failed to ensure that where bed rails are used, residents are assessed in accordance with prevailing practices, to minimize risk to the resident.

Log: 029540-16

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care(MOHLTC), Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used as a ``best practice document``. The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. These documents referred to in the HC Guidance Document are identified as useful resources to assess individual resident needs related to the use of bed rails. One document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S., FDA, 2003) provides necessary guidance in establishing a clinical assessment where bed rails are used. The document provides guidance for an individualized, systematic and documented approach and is intended to guide the development of resident care plans. It is identified that the population at risk for entrapment are residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain,

uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that would cause them to move about the bed or try to exit from the bed. The clinical decision making framework is for individualized resident assessment for the use- not to use bed rails with the approval from the interdisciplinary team. Input is also to be sought from the resident, family or legal guardian. The process is to include a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. Documentation of the risk-benefit assessment is required. The assessment takes into consideration numerous factors including (but not limited to): the resident's medical needs, sleeping habits, cognition and bed mobility. Diagnoses, symptoms, conditions and /or behavioural symptoms for which the use of a bed rails is being considered are to be addressed. Nursing/medical and environmental interventions are to be identified. The decision to use bed rails is to be approved by the interdisciplinary team that assessed the resident and the effectiveness of the use of the bed rail is to be reviewed regularly. The second document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce Risk of Entrapment" (FDA, 2006) guides an interdisciplinary group to evaluate bed systems by providing dimensional limits and test methods for measuring gaps in hospital beds.

A Critical Incident Report was submitted to the Director of the MOHLTC describing an unwitnessed fall incident in resident #004's bedroom. The resident was found at the bedside by a family member, with no sustained injury.

Resident #004 current disease state requires specific interventions for bed mobility. The resident's current care plan specifies extensive two-person staff assistance, padded bed rails and padding. The resident is cognitively impaired and was non-verbal in the presence of Inspector #548.

On March 27, 2017 Inspector #548 observed the bed belonging to resident #004. The bed was in the flat position, both full length side rails with rail covers applied were engaged in the up position. Padding was applied. The resident was observed to be sitting upright with the ability to move all extremities.

On March 27, 2017 during an interview resident's #004 family member indicated that the use of full rails and bed padding were required.

On March 27, 2017 during an interview with Inspector #548 RPN #101 indicated that resident #004 has an ability to move about the bed on their own accord. RPN #101 indicated that padding reduced gaps in the bed.

On March 28, 2017 during an interview with Inspector #548 the Clinical Care Coordinator (CCC) indicated the resident was found by a family member and the bed rails were observed to remain engaged in the up position. She added that the registered nursing staff assessed the resident for the need for two full length rails using the "Physical Restraint Intervention" form.

On March 29, 2017 during an interview with Inspector #548 the Administrator and CCC indicated that the form "Physical Restraint Intervention" is completed on a quarterly basis for all residents to determine the need for the use of bed rails.

The electronic "Physical Restraint Intervention" form prompts nursing staff to complete the quarterly assessment of observations, interventions and recommendations. Each section has drop down menu items related to the use of physical restraints prompting the staff member to select. Review of the "Physical Restraint Intervention" for resident #004 dated for a specific dated in September, 2016 made no specific reference to sleep habits- sleeping/non-sleeping, there was no documentation of previously attempted interventions and their effectiveness and, in the recommendation section staff are to determine the number of full rails that are to be used- one or two.

On April 21, 2017 during an interview with the inspector #548 CCC indicated that when resident #004 was admitted the family requested the use of two full rails and there were trials for a fall mat at that time. Resident #004 has had two full side rails since admission.

As per the FDA (2003) clinical guidance document- the framework for the regular review for each individual resident is to have the documented approval by an interdisciplinary team for the use of bed rails. As well, clinical and environmental interventions are to be addressed. If an intervention proves unsuccessful in meeting resident's #004 assessed needs, or a determination is made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment should be in the resident's health care record.

The assessment for resident #004 did not provide for the trialling of alternative interventions, as indicated nor was there a risk-benefit analysis conducted or documented.

As reported by Administrator and CCC on April 21, 2017 all residents use a specific type of bed rail in the home. As recorded on the Bed/Mattress Check List as of March 26, 2107 either full, half and ¼ rails (Licensee calls assistive rails) are in use for all 160 residents.

On April 21, 2017 during an interview with Inspector #548 the Administrator indicated that each resident received an assessment by the interdisciplinary team for the use or not to use bed rails however, the Administrator was not able to provide documentation of who the team consisted of to the inspector. In addition, the Administrator indicated that there was no risk-benefit analysis completed for any of the residents in the home to determine the use or not-to-use bed rails as specified in the FDA (2003) guidance document.

A compliance order is warranted as the scope of non-compliance described is widespread given the number of residents utilizing one or more bed rails. The non-compliance presents the potential for actual harm to all residents. On March 4, 2016 during the Resident Quality Inspection # 2016_384161_0006 a voluntary plan of correction was issued related to r. 15 (1) (a). A compliance order will be served on the Licensee. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

Issued on this 23 day of May 2017 (A1)

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

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St, Suite 420
OTTAWA, ON, K1S-3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston, bureau 420
OTTAWA, ON, K1S-3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : RUZICA SUBOTIC-HOWELL (548) - (A1)

Inspection No. / No de l'inspection : 2017_582548_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 020977-16, 022883-16, 029540-16 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : May 23, 2017;(A1)

Licensee / Titulaire de permis : Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner
2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6

LTC Home / Foyer de SLD : GARDEN TERRACE
100 Aird Place, KANATA, ON, K2L-4H8

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Christine Schyf

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 :

Ontario

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

The licensee is ordered to:

1. Develop and implement a documented interdisciplinary team assessment process for all residents with one or more bed rails in use, and for all residents for which the use of one or more bed rails are being considered. The process shall include a sleeping environment assessment and the observation of the resident in bed, for a specified period of time. The individual resident assessment and sleeping environment assessment shall specifically include all factors, elements and conditions as outlined in 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). As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document. The names of the team members, their assessment and recommendations are to be documented in the resident's health care record.

2. Ensure the interdisciplinary team assessment process identify potential clinical and environmental interventions which may serve as an alternative to bed rail use. Documentation of the risk-benefit assessment must be apparent in the resident's health care record.

3. Update resident's written plan of care to reflect the interdisciplinary team assessment. Include all required information as specified in the 'Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (USFDA, 2003).

Grounds / Motifs :

1. The Licensee failed to ensure that where bed rails are used, residents are assessed in accordance with prevailing practices, to minimize risk to the resident.

Log: 029540-16

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care(MOHLTC), Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards,

Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used as a ``best practice document``. The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. These documents referred to in the HC Guidance Document are identified as useful resources to assess individual resident needs related to the use of bed rails. One document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S., FDA, 2003) provides necessary guidance in establishing a clinical assessment where bed rails are used. The document provides guidance for an individualized, systematic and documented approach and is intended to guide the development of resident care plans. It is identified that the population at risk for entrapment are residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that would cause them to move about the bed or try to exit from the bed. The clinical decision making framework is for individualized resident assessment for the use- not to use bed rails with the approval from the interdisciplinary team. Input is also to be sought from the resident, family or legal guardian. The process is to include a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. Documentation of the risk-benefit assessment is required. The assessment takes into consideration numerous factors including (but not limited to): the resident's medical needs, sleeping habits, cognition and bed mobility. Diagnoses, symptoms, conditions and /or behavioural symptoms for which the use of a bed rails is being considered are to be addressed. Nursing/medical and environmental interventions are to be identified. The decision to use bed rails is to be approved by the interdisciplinary team that assessed the resident and the effectiveness of the use of the bed rail is to be reviewed regularly. The second document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce Risk of Entrapment" (FDA, 2006) guides an interdisciplinary group to evaluate bed systems by providing dimensional limits and test methods for measuring gaps in hospital beds.

A Critical Incident Report was submitted to the Director of the MOHLTC describing an unwitnessed fall incident in resident #004's bedroom. The resident was found at the bedside by a family member, with no sustained injury.

Resident #004 current disease state requires specific interventions for bed mobility. The resident's current care plan specifies extensive two-person staff assistance,

padded bed rails and padding. The resident is cognitively impaired and was non-verbal in the presence of Inspector #548.

On March 27, 2017 Inspector #548 observed the bed belonging to resident #004. The bed was in the flat position, both full length side rails with rail covers applied were engaged in the up position. Padding was applied. The resident was observed to be sitting upright with the ability to move all extremities.

On March 27, 2017 during an interview resident's #004 family member indicated that the use of full rails and bed padding were required.

On March 27, 2017 during an interview with Inspector #548 RPN #101 indicated that resident #004 has an ability to move about the bed on their own accord. RPN #101 indicated that padding reduced gaps in the bed.

On March 28, 2017 during an interview with Inspector #548 the Clinical Care Coordinator (CCC) indicated the resident was found by a family member and the bed rails were observed to remain engaged in the up position. She added that the registered nursing staff assessed the resident for the need for two full length rails using the "Physical Restraint Intervention" form.

On March 29, 2017 during an interview with Inspector #548 the Administrator and CCC indicated that the form "Physical Restraint Intervention" is completed on a quarterly basis for all residents to determine the need for the use of bed rails.

The electronic "Physical Restraint Intervention" form prompts nursing staff to complete the quarterly assessment of observations, interventions and recommendations. Each section has drop down menu items related to the use of physical restraints prompting the staff member to select. Review of the "Physical Restraint Intervention" for resident #004 dated for a specific dated in September, 2016 made no specific reference to sleep habits- sleeping/non-sleeping, there was no documentation of previously attempted interventions and their effectiveness and, in the recommendation section staff are to determine the number of full rails that are to be used- one or two.

On April 21, 2017 during an interview with the inspector #548 CCC indicated that when resident #004 was admitted the family requested the use of two full rails and there were trials for a fall mat at that time. Resident #004 has had two full side rails

since admission.

As per the FDA (2003) clinical guidance document- the framework for the regular review for each individual resident is to have the documented approval by an interdisciplinary team for the use of bed rails. As well, clinical and environmental interventions are to be addressed. If an intervention proves unsuccessful in meeting resident's #004 assessed needs, or a determination is made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used. Documentation of the risk-benefit assessment should be in the resident's health care record.

The assessment for resident #004 did not provide for the trialling of alternative interventions, as indicated nor was there a risk-benefit analysis conducted or documented.

As reported by Administrator and CCC on April 21, 2017 all residents use a specific type of bed rail in the home. As recorded on the Bed/Mattress Check List as of March 26, 2107 either full, half and ¼ rails (Licensee calls assistive rails) are in use for all 160 residents.

On April 21, 2017 during an interview with Inspector #548 the Administrator indicated that each resident received an assessment by the interdisciplinary team for the use or not to use bed rails however, the Administrator was not able to provide documentation of who the team consisted of to the inspector. In addition, the Administrator indicated that there was no risk-benefit analysis completed for any of the residents in the home to determine the use or not-to-use bed rails as specified in the FDA (2003) guidance document. (548)

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

Jun 19, 2017(A1)

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

Ministère 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

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

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

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
Télécopieur : 416-327-7603

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

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
Télécopieur : 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 23 day of May 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : RUZICA SUBOTIC-HOWELL

Service Area Office /
Bureau régional de services : Ottawa