Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 1, 2017	2017_539120_0021	025544-16	Follow up

Licensee/Titulaire de permis

THE THOMAS HEALTH CARE CORPORATION
490 Highway #8 STONEY CREEK ON L8G 1G6

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

PINE VILLA NURSING HOME
490 HIGHWAY #8 STONEY CREEK ON L8G 1G6

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 29, 2017

An inspection (2016-189120-0044) was previously conducted July 2016, and non-compliance identified related to resident clinical assessments where bed rails are used. An order with multiple conditions was issued on August 2, 2016. For this follow up inspection, most of the conditions in the order were determined to remain outstanding.

During the course of the inspection, the inspector(s) spoke with the Administrator and Clinical Lead.

During

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)**
- **1 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.

An inspection (2016-189120-0044) was previously conducted July 2016, and non-compliance identified with this section related to resident clinical assessments where bed rails were used. An order with multiple conditions was issued on August 2, 2016, and included requirements to amend the home's existing forms to include; (1) the alternatives that were trialled prior to the application of one or more bed rails and to document whether the alternatives were effective, (2) to include the names of the interdisciplinary team members who participated in the assessments, (3) clear written directions to assist the assessor in determining whether bed rails were a safe alternative for the resident, and (4) to amend the policy to include requirements (1) to (3). 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.

The licensee's bed rail use clinical assessment forms and processes were reviewed and it was determined that the requirements specified in the order were not fully complied with. According to the Clinical Lead, the Clinical Guidance document was reviewed and their forms and policy amended. However, when the forms were reviewed, they were either not completed, were confusing or were missing additional information. For this follow up inspection, four residents (#001 to #004) were selected for review to determine

whether they were assessed for bed rail safety in accordance with the clinical guidance document and if risks were identified, evaluated and mitigated if necessary.

The licensee developed two forms for completion by a registered nurse. The first form was titled "Bed Rail Use Assessment Tool", which included questions for the registered nurse to ask the resident or SDM related to bed rail use, past use, past injuries related to bed rail use, past falls from bed, current medical issues, current sleep disorders and communication needs. The answers were to guide the registered nurse in deciding whether alternatives or interventions would be needed before proceeding to a sleep observation process. The form included a section that listed several "interventions" to mitigate falls to the floor (bed height, bed alarm, falls arrest mattress, staff monitoring and assistance), assist with communications (call bell) and one alternative (bolsters) which was not clearly defined. The selection of alternatives to using the hard "bed rails" are limited, but include a lipped or beveled mattress (which were in use in the home), hand grips, adjustable and removable bolsters (soft rails) or a transfer pole. The form was not designed to include documentation as to when the alternatives were trialled, for how long and if effective or not. The form included a "bed rail recommendation" section and rationale for bed rail use.

The second form was titled "Bed Rail Use Observation Tool" and was specifically developed to document what was observed while residents were in bed, initially without a bed rail for a period of 24-72 hours, followed by a period of observation with bed rails for 72 hours. It also included the same options as the "Bed Rail Use Assessment Tool" related to interventions and was not designed to include documentation as to when the alternatives were trialled, for how long and if effective or not. The form included a "bed rail recommendation" section and rationale for bed rail use. It was implemented in November 2016. It included relevant questions related to sleep patterns and behaviours that the registered nurse or personal support workers (PSWs) could answer by selecting either a "yes" or "no" response while observing the residents sleeping. However, the form did not include a section staff could complete after the period of observation without bed rails and before moving onto the period of observation with bed rails. It did not include a clear guide to identify if staff should proceed to an observation period with bed rails. According to the home's policy titled "Use of Bed Side Rail" (revised November 5, 2016) under a section titled "Appendix B", some parameters were listed for residents considered to be at low risk or at high risk for bed related injuries. However, the parameters for a high risk category did not include cognition, sleep disorders, behaviours, conditions causing involuntary body movements or medication use (causing altered states), all of which increase the resident's risk of becoming entrapped,

suspended or injured while in bed with one or more bed rails applied.

The licensee's policy titled "Use of Bed Side Rail" (revised November 5, 2016) directed registered nurses to "assess the resident for bed rail risk on admission and re-admission within 24 hours of admission using the "Bed Rail Use Observation Tool". Residents #001, #002 and #003 were all admitted to the home after November 30, 2016, and were all identified to require one or more bed rails. A completed "Bed Rail Use Observation" form for the period of observation with bed rails applied was not completed for any of the three residents. Determining what the possible risks were for those residents while in bed with bed rails applied was therefore unknown. A total of eleven residents were identified to require at least one or more bed rails in the home, and seven were not fully assessed which included residents #001, #002 and #003.

Neither of the two assessment forms specified what interdisciplinary staff members participated in the evaluation of the resident with the exception of the registered nurse. According to the Clinical Lead, registered staff members and personal support workers who worked on the night shift were both involved in observing residents while asleep and collaborated with each other to complete the forms. The home's policy did not include the PSW role in observing residents while asleep and liasing with nursing staff to establish risk factors.

A) Resident #001, was admitted to the home in January 2017, and had a written plan of care that required the resident to have "one short bed rail up for positioning on left side". The resident was observed in bed at the time of inspection with two three-quarter length bed rails elevated. A specialized bed accessory was also seen on top of the foam bed mattress. The resident was cognitively well and was able to report how they used both bed rails. Both forms were available for review, however it appeared that the resident slept the first night with bed rails in place and the section related to risk factors related to the resident sleeping in bed with bed rails was not completed. A conclusion or rationale of the risks over the benefits of the specialized bed accessory and the bed rails was absent on the assessments. The Bed Rail Use Assessment Tool form was not signed by any staff member. The reason for the specialized bed accessory was not identified in the resident's written plan of care. According to the home's policy, and the Clinical Guide document, the use of accessory products must be assessed and any risks identified and mitigated and interventions included in the resident's plan of care.

B) Resident #002 was admitted to the home in January 2011, and had a written plan of care that required the resident to have "one short bed rail up when in bed and at night for

positioning self". No side to apply the bed rail was identified. The resident's bed system was observed during the inspection and was noted to be equipped with two 3/4 bed rails on the bed (lowered). The resident was assessed in August 2016, using the "Bed Rail Use Assessment Tool" and it is unknown if the resident was formally observed sleeping in bed with or without the bed rails as a "Bed Rail Use Observation Tool" was missing. The resident, based on the initial questions, was identified to have multiple risk factors related to bed rail use related to cognition, repositioning, sleeping behaviours and mobility challenges. The interventions selected did not include bolsters or other options to replace the hard bed rails, considering the many risk factors identified. The assessment included a statement that a short bed rail was required on the right side to assist with positioning and no risk over benefit rationale was given.

C) Resident #003 was admitted to the home in December 2016, and had a written plan of care that required the resident to have "one short bed rail up when in bed to help with positioning in and out of bed". No side to apply the bed rail was identified. The resident was assessed on the same date using the "Bed Rail Use Assessment Tool" and was not observed sleeping in bed with or without the bed rails (based on the dates on both of the forms). The resident, based on the initial questions asked upon admission, was identified to have multiple risk factors related to bed rail related to sleeping behaviours, cognition, communication, repositioning and mobility issues. The interventions selected did not include bolsters or other options to replace the hard bed rails, considering the many risk factors identified. The assessment included a statement that a short bed rail was required (no side identified) for positioning without a rationale of risks over benefits. The resident's bed system was observed to be equipped with two 3/4 rails attached to the bed (lowered). The bed rails were not "short" and extended just past half the length of the bed. Discussion was held with the Clinical Lead regarding the confusion of how the 3/4 length bed rails became known as the "short" bed rail when a number of other beds in the home were observed to be equipped with quarter length bed rails. The home's policy included drawings of bed rails and the various lengths but did not direct registered nurses to ensure that the correct bed rail length and the side or sides applied be included in the resident's plan of care.

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

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

Issued on this 8th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2017_539120_0021
Log No. / Registre no:	025544-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 1, 2017
Licensee / Titulaire de permis :	THE THOMAS HEALTH CARE CORPORATION 490 Highway #8, STONEY CREEK, ON, L8G-1G6
LTC Home / Foyer de SLD :	PINE VILLA NURSING HOME 490 HIGHWAY #8, STONEY CREEK, ON, L8G-1G6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lily Wang

To THE THOMAS HEALTH CARE CORPORATION, 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_189120_0044, CO #001;

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 "Bed Rail Use Assessment Tool" to include a section to document what alternative(s) were trialled prior to using one or more bed rails, the dates that the alternative(s) were trialled and whether the alternative(s) were effective or not.

2. Amend one or both of the the home's existing forms related to resident bed system clinical assessments to include the names and signatures of the interdisciplinary team that were involved in the clinical assessment.

3. 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.

4. Re-assess all seven residents who use one or more bed rails using the amended assessment form or forms using an interdisciplinary team and document the assessed results and recommendations for each of the seven residents within 7 days of the date of this order.

5. Update the written plan of care for those seven residents where changes were identified after re-assessing each resident who requires one or more bed rails using the amended bed safety assessment form(s). Include in the written plan of care the accurate size or type of bed rail, the side or sides the bed rail(s) shall be applied and when the bed rail(s) shall be applied.

6. For resident #001, where a specialized bed accessory was required, document what bed safety assessments were completed and any necessary interventions that were required to mitigate any identified bed safety hazards.

7. Amend the existing policy tilted "Use of Bed Side Rail" (November 5, 2016) so that the assessor has clear guidance in completing resident bed system clinical assessments. The policy shall include the following; role of the PSW in observing residents while sleeping in bed, direction with respect to how long resident's will be observed in bed with and without bed rails applied, how long residents will be observed in bed with and without alternatives applied, what types of alternatives are available to replace hard bed rails and what specific sleeping patterns, habits and behaviours are associated with an increase in bed related injuries or would place a resident in a high risk category for bed related injury.

Grounds / Motifs :

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

An inspection (2016-189120-0044) was previously conducted July 2016, and non-compliance identified with this section related to resident clinical assessments where bed rails were used. An order with multiple conditions was issued on August 2, 2016, and included requirements to amend the home's existing forms to include; (1) the alternatives that were trialled prior to the application of one or more bed rails and to document whether the alternatives were effective, (2) to include the names of the interdisciplinary team members

who participated in the assessments, (3) clear written directions to assist the assessor in determining whether bed rails were a safe alternative for the resident, and (4) to amend the policy to include requirements (1) to (3). 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.

The licensee's bed rail use clinical assessment forms and processes were reviewed and it was determined that the requirements specified in the order were not fully complied with. According to the Clinical Lead, the Clinical Guidance document was reviewed and their forms and policy amended. However, when the forms were reviewed, they were either not completed, were confusing or were missing additional information. For this follow up inspection, four residents (#001 to #004) were selected for review to determine whether they were assessed for bed rail safety in accordance with the clinical guidance document and if risks were identified, evaluated and mitigated if necessary.

The licensee developed two forms for completion by a registered nurse. The first form was titled "Bed Rail Use Assessment Tool", which included questions for the registered nurse to ask the resident or SDM related to bed rail use, past use, past injuries related to bed rail use, past falls from bed, current medical issues, current sleep disorders and communication needs. The answers were to guide the registered nurse in deciding whether alternatives or interventions would be needed before proceeding to a sleep observation process. The form included a section that listed several "interventions" to mitigate falls to the floor (bed height, bed alarm, falls arrest mattress, staff monitoring and assistance), assist with communications (call bell) and one alternative (bolsters) which was not clearly defined. The selection of alternatives to using the hard "bed rails" are limited, but include a lipped or beveled mattress (which were in use in the home), hand grips, adjustable and removable bolsters (soft rails) or a transfer pole. The form was not designed to include documentation as to when the alternatives were trialled, for how long and if effective or not. The form included a "bed rail recommendation" section and rationale for bed rail use.

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bed, initially without a bed rail for a period of 24-72 hours, followed by a period of observation with bed rails for 72 hours. It also included the same options as the "Bed Rail Use Assessment Tool" related to interventions and was not designed to include documentation as to when the alternatives were trialled, for how long and if effective or not. The form included a "bed rail recommendation" section and rationale for bed rail use. It was implemented in November 2016. It included relevant questions related to sleep patterns and behaviours that the registered nurse or personal support workers (PSWs) could answer by selecting either a "yes" or "no" response while observing the residents sleeping. However, the form did not include a section staff could complete after the period of observation without bed rails and before moving onto the period of observation with bed rails. It did not include a clear guide to identify if staff should proceed to an observation period with bed rails. According to the home's policy titled "Use of Bed Side Rail" (revised November 5, 2016) under a section titled "Appendix B", some parameters were listed for residents considered to be at low risk or at high risk for bed related injuries. However, the parameters for a high risk category did not include cognition, sleep disorders, behaviours, conditions causing involuntary body movements or medication use (causing altered states), all of which increase the resident's risk of becoming entrapped, suspended or injured while in bed with one or more bed rails applied.

The licensee's policy titled "Use of Bed Side Rail" (revised November 5, 2016) directed registered nurses to "assess the resident for bed rail risk on admission and re-admission within 24 hours of admission using the "Bed Rail Use Observation Tool". Residents #001, #002 and #003 were all admitted to the home after November 30, 2016, and were all identified to require one or more bed rails. A completed "Bed Rail Use Observation" form for the period of observation with bed rails applied was not completed for any of the three residents. Determining what the possible risks were for those residents while in bed with bed rails applied was therefore unknown. A total of eleven residents were identified to require at least one or more bed rails in the home, and seven were not fully assessed which included residents #001, #002 and #003.

Neither of the two assessment forms specified what interdisciplinary staff members participated in the evaluation of the resident with the exception of the registered nurse. According to the Clinical Lead, registered staff members and personal support workers who worked on the night shift were both involved in observing residents while asleep and collaborated with each other to complete the forms. The home's policy did not include the PSW role in observing residents

while asleep and liasing with nursing staff to establish risk factors.

A) Resident #001, was admitted to the home in January 2017, and had a written plan of care that required the resident to have "one short bed rail up for positioning on left side". The resident was observed in bed at the time of inspection with two three-quarter length bed rails elevated. A specialized bed accessory was also seen on top of the foam bed mattress. The resident was cognitively well and was able to report how they used both bed rails. Both forms were available for review, however it appeared that the resident slept the first night with bed rails in place and the section related to risk factors related to the resident sleeping in bed with bed rails was not completed. A conclusion or rationale of the risks over the benefits of the specialized bed accessory and the bed rails was absent on the assessments. The Bed Rail Use Assessment Tool form was not signed by any staff member. The reason for the specialized bed accessory was not identified in the resident's written plan of care. According to the home's policy, and the Clinical Guide document, the use of accessory products must be assessed and any risks identified and mitigated and interventions included in the resident's plan of care.

B) Resident #002 was admitted to the home in January 2011, and had a written plan of care that required the resident to have "one short bed rail up when in bed and at night for positioning self". No side to apply the bed rail was identified. The resident's bed system was observed during the inspection and was noted to be equipped with two 3/4 bed rails on the bed (lowered). The resident was assessed in August 2016, using the "Bed Rail Use Assessment Tool" and it is unknown if the resident was formally observed sleeping in bed with or without the bed rails as a "Bed Rail Use Observation Tool" was missing. The resident, based on the initial questions, was identified to have multiple risk factors related to bed rail use related to cognition, repositioning, sleeping behaviours and mobility challenges. The interventions selected did not include bolsters or other options to replace the hard bed rails, considering the many risk factors identified. The assessment included a statement that a short bed rail was required on the right side to assist with positioning and no risk over benefit rationale was given.

C) Resident #003 was admitted to the home in December 2016, and had a written plan of care that required the resident to have "one short bed rail up when in bed to help with positioning in and out of bed". No side to apply the bed rail was identified. The resident was assessed on the same date using the "Bed Rail Use Assessment Tool" and was not observed sleeping in bed with or

without the bed rails (based on the dates on both of the forms). The resident, based on the initial questions asked upon admission, was identified to have multiple risk factors related to bed rail related to sleeping behaviours, cognition, communication, repositioning and mobility issues. The interventions selected did not include bolsters or other options to replace the hard bed rails, considering the many risk factors identified. The assessment included a statement that a short bed rail was required (no side identified) for positioning without a rationale of risks over benefits. The resident's bed system was observed to be equipped with two 3/4 rails attached to the bed (lowered). The bed rails were not "short" and extended just past half the length of the bed. Discussion was held with the Clinical Lead regarding the confusion of how the 3/4 length bed rails became known as the "short" bed rail when a number of other beds in the home were observed to be equipped with quarter length bed rails. The home's policy included drawings of bed rails and the various lengths but did not direct registered nurses to ensure that the correct bed rail length and the side or sides applied be included in the resident's plan of care.

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

This order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s. 15(1) of Ontario Regulation 79/10, the scope of the non-compliance is 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 November 2, 2015 and August 2, 2016. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 31, 2017

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 1st day of May, 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