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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 10, 2018	2018_617148_0008	025590-17	Follow up

Licensee/Titulaire de permis

458422 Ontario Limited
220 Emma Street CORNWALL ON K6J 5V8

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

Sandfield Place
220 Emma Street CORNWALL ON K6J 5V8

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

AMANDA NIXON (148)

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 14, 15 and 19, 2018

This inspection was to follow up on a Compliance Order issued October 24, 2017 (#2107 617148 0027) related to O.Regulation 79/10, s.15(1)(a), specifically related to bed system evaluations and resident assessments for the use of bed rails.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, Director of Care, Nursing Clerk/Back-up RAI Coordinator, Registered Nurses (RN), Personal Support Workers (PSW) and residents.

The inspector observed resident bed systems and reviewed identified resident health care records in addition to various documents related to bed evaluations and resident assessments specific to the use of bed rails.

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

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

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, residents were assessed and his or her bed system was evaluated in accordance with evidence-based practices and in accordance with prevailing practices, to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Specifically, the staff responsible for bed evaluations did not evaluate all intermediate positions of the rotating assist rail used by residents in the home. In addition, the licensee did not ensure that the resident assessment is conducted by an interdisciplinary team, that the risk-benefit analysis is documented and that the resident assessment is conducted prior to the use of bed rails.

On October 24, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_617148_0027. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by January 31, 2018.

The licensee was ordered to:
1. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment. The interventions identified in the Health Canada Guidance Document companion document, "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (U.S. FDA June, 2006), shall be

considered for each resident and their bed system, including those bed systems with a therapeutic surface such as low air loss mattresses (LAL). This will be done using an individualized, systematic and documented approach. These actions must be completed within 14 days of this order being served.

2. Where bed rails are used, evaluate any bed systems that were modified after the May, 2017, bed system evaluation, in accordance with evidence-based practices in order to minimize risk to the resident. Where it is unknown whether the bed system was or was not modified after the May, 2017, bed system evaluation, evaluate the bed system. This must be completed within 14 days of this order being served.

3. Establish and implement a process for ensuring that all future bed system failures are addressed immediately by taking the necessary corrective actions in accordance with the Health Canada companion document titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (U.S. FDA, June, 2006).

4. Amend the process by which residents are assessed for the use of bed rails. Ensure all residents with one or more bed rails in use, and all residents for which the use of one or more bed rails is being considered, are individually assessed by an interdisciplinary team. The assessment process shall include a sleeping environment assessment; and shall include all factors, elements and conditions 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.

5. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes which may serve as alternatives to bed rail use; and, that the interventions or changes are trialed if appropriate and dependent on the resident assessment.

6. Ensure that the interdisciplinary team clearly documents all assessments and the results of the assessment or reassessment, including the risk-benefit analysis and ensuing recommendations.

7. Ensure that the interdisciplinary team reassess all residents for the use of bed rails, at a minimum, whenever there is a change in the resident's health status, as recommended in the Health Canada Guidance Document.

8. Update the written plan of care based on the resident assessment or reassessment by the interdisciplinary team for all residents where bed rails are used. Include all required information as specified in the FDA, 2003 clinical guidance document. Provide clear directions and include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

The licensee implemented appropriate interventions to mitigate the risk of entrapment, established and implemented a process for ensuring that all future bed systems failures are addressed immediately, amended the process by which residents are assessed for the use of bed rails and ensured a process to identify potential interventions which may serve as alternatives to bed rail use.

The licensee did not ensure that bed systems were evaluated in accordance with evidence-based practices, that an interdisciplinary team conducted and documented all assessments including the risk-benefit analysis and that the written plan of care was based on assessment providing clear directions to staff.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4). The HC guidance document describes the bed evaluation to include testing of intermediate position; such as those found with the use of rotating assist rails.

The HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) of the United States. The companion documents referred to in the HC guidance document are identified as useful resources and outline prevailing practices related to the use of bed rails.

Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision making. One of the companion documents is 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). According to the companion document, evaluation is needed to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. A decision regarding the use of the bed rails is to be made within the context of an individualized resident assessment using an interdisciplinary team with input from the resident and family or substitute decision maker. The process is to result in a documented risk-benefit analysis prior to the team's conclusion that bed rails may be indicated for use.

Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:
a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.
b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.
c) 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.

The 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Sandfield Place is a long-term care home with 53 licensed beds. At the time of the inspection it was identified that the home had various bed rails in use, most commonly used were rotating assist rails or 1/4 length rails.

Inspector #148 spoke with the home's Administrator and Director of Care regarding the program in place for bed evaluations and resident assessment with regards to the use of bed rails in the home. Both senior managers identified Nursing Clerk #101 and the home's RAI Coordinator #102, as the leads for this program.

Inspector #148 observed nine bed systems and discussed each with Nursing Clerk #101. Eight of the nine beds observed had two rotating assist rails in use, in either the guard or

assist position. In discussion with Staff member #101 it was reported that the home had purchased several new bed frames of which were equipped with rotating assist rails. Staff member #101 reported that the bed evaluations completed were done so with the rails in the guard position. Staff member #101 said that if the resident did not require the rotating assist rail it would be placed in the assist position and was not considered to require evaluation. Staff member #101 described that the rails were only seen to pose risk if in the guard position. During the interview staff member #101 was not aware that the rotating assist rails could be removed if the resident did not require them for use. It was determined that not all intermediate positions of the rotating assist rail were tested as part of the bed evaluations.

Inspector #148 spoke with Nursing Clerk #101 regarding the resident assessment as it relates to the use of bed rails. The Restraint/PASD Assessment V3, section 3a was identified as the tool used to assess the relative risk of a resident using bed rails. Staff member #101 indicated that in most instances the day RN will complete this tool. In review of the tool, factors such as medication, diagnosis, behaviours, communication and cognition were not included in the tool. The Inspector reviewed the tool and interviewed regular day RN #103. RN #103 reported that the tool is completed by the registered nurse, RN #103 said that the assessment is conducted over a seven day period, specifically in conjunction with the Minimum Data Set assessment time frames for new admissions and when the resident has as change in health status. During the interview, RN #103 was able to independently identify the factors noted above as being part of the resident assessment completed, however they were not documented within the identified tool. When asked, RN #103 said that when the assessment tool is completed the RN will consult with Staff member #101 and/or staff member #102 and PSWs to decide if the resident is safe using the bed rails. When asked how that determination is made, RN #103 said that if the resident is using the rails and there is no identified potential harm, then the use of the bed rails will continue. In discussion of a resident newly admitted to the home or whereby there is an internal bed transfer, it was identified that this may place a resident in a bed system with one or more bed rails applied; Staff member #101 and RN #103 noted that the bed rails in place would remain on the bed system. This would place a resident in a bed system with rails applied prior to having completed the resident assessment. In interview with both Staff member #101 and RN #103 it was determined that at this time there is no risk-benefit analysis included in the resident assessment. In interviews with the home's Administrator, Director of Care, Staff member #101 and RN #103, the home does not have a process in place for an interdisciplinary resident assessment and risk-benefit analysis. The resident assessment and decision making is conducted by nursing staff members.

Inspector #148 observed eight resident bed systems and found the following bed rails in use:
Resident #002 – 1 rail in the assist position, 1 rail in the guard position
Resident #003 - 1 rail in the assist position, 1 rail in the guard position
Resident #004 - 1 rail in the assist position, 1 rail in the guard position
Resident #005 – both rails in the assist position
Resident #006 - both rails in the guard position (resident observed in bed)
Resident #007 - 1 rail in the assist position, 1 rail in the guard position (resident observed in bed)
Resident #008 – two ¼ rails at the head of bed (resident observed in bed)
Resident #009 – both rails in the assist position

The Inspector reviewed the health care records of the identified residents above and spoke with PSW staff members regarding the use of the above observed bed rails. The plan of care for resident #002 indicates the use of one bed rail as a personal assistive service device (PASD) for mobility. Staff confirmed that the resident uses the rail in the assist position, but does not use the rail in the guard position. The plan of care for resident #003 indicates the use of both bed rails as it relates to fall risk. Staff confirmed the resident does not use the rails for positioning, nor can the resident move in bed on their own. The plan of care for resident #004 indicates the use of one rail as a PASD. Staff confirmed that the resident uses the bed rail in the assist position for transferring, but does not use the bed rail in the guard position. The plan of care for resident #005 indicates the use of one bed rail as a PASD. Staff confirmed that the resident uses one of the bed rails in the assist position and was not sure if the second bed rail was used. The plan of care for resident #006 was unspecific to the use of bed rails. Staff confirmed that the bed rails are both used in the guard position to keep the resident's body in the bed. The plan of care for resident #007 was unspecific to the use of bed rails. Staff confirmed that the bed rail in the assist position was used for transfers and the bed rail in the guard position was used for bed mobility. The plan of care for resident #008 was unspecific to the use of bed rails. Staff confirmed that only one bed rail is used for bed mobility. The plan of care for resident #009 indicates the use of ¼ bed rails as a PASD. Staff confirmed that the bed rails in the assist position are used for transfers.

The plans of care for the identified residents were unspecific to the type/number of bed rail(s) to be used or the position of the rail(s) applied. The observed use of rails on bed systems was not consistent to the planned care related to the use of bed rails.

As described above the licensee has failed to ensure that the bed systems are evaluated in accordance with best practices, specifically as it relates to the evaluation of intermediate positions and has failed to ensure that resident assessments and risk-benefit analysis are conducted by an interdisciplinary team prior to the application of bed rails. In addition, the licensee failed to ensure that the plans of care provide clear directions for staff in the use of bed rails. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 11th day of April, 2018

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) :	AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2018_617148_0008
Log No. / No de registre :	025590-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 10, 2018
Licensee / Titulaire de permis :	458422 Ontario Limited 220 Emma Street, CORNWALL, ON, K6J-5V8
LTC Home / Foyer de SLD :	Sandfield Place 220 Emma Street, CORNWALL, ON, K6J-5V8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Bill Kinnear

To 458422 Ontario Limited, 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: 2017_617148_0027, 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 must be compliant with s.15(1) of the LTCHA.

Specifically, the licensee shall ensure:

1) Bed systems are evaluated in accordance with evidence-based practice to ensure that, as it relates to rotating assist rails, all intermediate positions are evaluated. The zone specific test results are to be documented;

2) Development of an interdisciplinary team who will then conduct and document all resident assessments including the risk-benefit analysis in accordance with prevailing practices. Resident assessments by the interdisciplinary team will be conducted prior to the application of bed rails; and

3) The written plan of care for each resident with bed rails in use, is based on an assessment of the resident providing clear directions to staff as it relates to the use of bed rails.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, residents

were assessed and his or her bed system was evaluated in accordance with evidence-based practices and in accordance with prevailing practices, to minimize risk to the resident and steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Specifically, the staff responsible for bed evaluations did not evaluate all intermediate positions of the rotating assist rail used by residents in the home. In addition, the licensee did not ensure that the resident assessment is conducted by an interdisciplinary team, that the risk-benefit analysis is documented and that the resident assessment is conducted prior to the use of bed rails.

On October 24, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_617148_0027. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by January 31, 2018.

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2. Where bed rails are used, evaluate any bed systems that were modified after the May, 2017, bed system evaluation, in accordance with evidence-based practices in order to minimize risk to the resident. Where it is unknown whether the bed system was or was not modified after the May, 2017, bed system evaluation, evaluate the bed system. This must be completed within 14 days of this order being served.

3. Establish and implement a process for ensuring that all future bed system failures are addressed immediately by taking the necessary corrective actions in accordance with the Health Canada companion document titled "A Guide for

Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (U.S. FDA, June, 2006).

4. Amend the process by which residents are assessed for the use of bed rails. Ensure all residents with one or more bed rails in use, and all residents for which the use of one or more bed rails is being considered, are individually assessed by an interdisciplinary team. The assessment process shall include a sleeping environment assessment; and shall include all factors, elements and conditions 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.

5. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes which may serve as alternatives to bed rail use; and, that the interventions or changes are trialed if appropriate and dependent on the resident assessment.

6. Ensure that the interdisciplinary team clearly documents all assessments and the results of the assessment or reassessment, including the risk-benefit analysis and ensuing recommendations.

7. Ensure that the interdisciplinary team reassess all residents for the use of bed rails, at a minimum, whenever there is a change in the resident's health status, as recommended in the Health Canada Guidance Document.

8. Update the written plan of care based on the resident assessment or reassessment by the interdisciplinary team for all residents where bed rails are used. Include all required information as specified in the FDA, 2003 clinical guidance document. Provide clear directions and include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

The licensee implemented appropriate interventions to mitigate the risk of entrapment, established and implemented a process for ensuring that all future bed systems failures are addressed immediately, amended the process by which residents are assessed for the use of bed rails and ensured a process to identify potential interventions which may serve as alternatives to bed rail use.

The licensee did not ensure that bed systems were evaluated in accordance with evidence-based practices, that an interdisciplinary team conducted and documented all assessments including the risk-benefit analysis and that the written plan of care was based on assessment providing clear directions to staff.

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Resident #003 - 1 rail in the assist position, 1 rail in the guard position
Resident #004 - 1 rail in the assist position, 1 rail in the guard position
Resident #005 – both rails in the assist position
Resident #006 - both rails in the guard position (resident observed in bed)
Resident #007 - 1 rail in the assist position, 1 rail in the guard position (resident observed in bed)
Resident #008 – two ¼ rails at the head of bed (resident observed in bed)
Resident #009 – both rails in the assist position

The Inspector reviewed the health care records of the identified residents above and spoke with PSW staff members regarding the use of the above observed bed rails. The plan of care for resident #002 indicates the use of one bed rail as a personal assistive service device (PASD) for mobility. Staff confirmed that the resident uses the rail in the assist position, but does not use the rail in the guard position. The plan of care for resident #003 indicates the use of both bed rails as it relates to fall risk. Staff confirmed the resident does not use the rails for positioning, nor can the resident move in bed on their own. The plan of care for resident #004 indicates the use of one rail as a PASD. Staff confirmed that the resident uses the bed rail in the assist position for transferring, but does not use the bed rail in the guard position. The plan of care for resident #005 indicates the use of one bed rail as a PASD. Staff confirmed that the resident uses one of the bed rails in the assist position and was not sure if the second bed rail was used. The plan of care for resident #006 was unspecific to the use of bed rails. Staff confirmed that the bed rails are both used in the guard position to keep the resident's body in the bed. The plan of care for resident #007 was unspecific to the use of bed rails. Staff confirmed that the bed rail in the assist position was used for transfers and the bed rail in the guard position was used for bed mobility. The plan of care for resident #008 was unspecific to the use of bed rails. Staff confirmed that only one bed rail is used for bed mobility. The plan of care for resident #009 indicates the use of ¼ bed rails as a PASD. Staff confirmed that the bed rails in the assist position are used for transfers.

The plans of care for the identified residents were unspecific to the type/number of bed rail(s) to be used or the position of the rail(s) applied. The observed use of rails on bed systems was not consistent to the planned care related to the use of bed rails.

As described above the licensee has failed to ensure that the bed systems are evaluated in accordance with best practices, specifically as it relates to the

evaluation of intermediate positions and has failed to ensure that resident assessments and risk-benefit analysis are conducted by an interdisciplinary team prior to the application of bed rails. In addition, the licensee failed to ensure that the plans of care provide clear directions for staff in the use of bed rails.

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 3, indicating wide spread, as the non-compliance relates to each resident observe with bed rails in use. The compliance history is a level 4 as non-compliance with this section of O.Regulation 79/10 has been issued as follows:
- Compliance Order issued October 24, 2017 (2017_617148_0027)

(148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 06, 2018

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 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, 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
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 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 de la Santé et 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers 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

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 10th day of April, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

Service Area Office /
Bureau régional de services : Ottawa Service Area Office