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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119 King Street West 11th Floor
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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 |
|---|---|---|---|
| Mar 20, 2017 | 2017_539120_0012 | 026385-16 | Follow up |

## Licensee/Titulaire de permis

FOYER RICHELIEU WELLAND
655 Tanguay Ave WELLAND ON L3B 6A1

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

FOYER RICHELIEU WELLAND
655 TANGUAY AVENUE WELLAND ON L3B 6A1

## 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): February 17, 2017**

**An inspection (2016-341583-0010) was previously conducted May 25-June 13, 2016, and an order issued on July 22, 2016, related to bed safety. For this follow-up inspection, a condition that was identified in the order was not met related to the development of a clinical bed safety assessment for residents who used one or more bed rails that was based on prevailing practices.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurse and Personal Support Workers.**

**During the course of the inspection, the inspector toured the home, observed the bed systems in the home and reviewed the written plan of care for selected residents, bed safety assessments and bed entrapment audits.**

**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<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 :**

The licensee did not ensure that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted between May 25 and June 13, 2016, and non-compliance was identified with this section. An order with multiple conditions was issued, one of which included the requirement to develop an interdisciplinary resident assessment to be used to assess all residents who had care directions for the use of bed rails in accordance with 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).

For this follow up inspection, three residents (#102, #103 and #104) 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. It was determined that the staff who participated in the assessments of the residents, where bed rails were used, did not complete or fully assess the residents in accordance with the directions as specified in the clinical guidance document.

According to the licensee's policy #09-03-01 titled "Resident Bed Safety", residents were to be assessed using a form titled "Resident Assessment for Bed Safety (RABS)" upon admission, quarterly, when there was a significant change in their health status and any changes to the resident's bed system. The policy did not include how many nights the resident was to be monitored, both with and without bed rails, whether alternatives were to be trialled and for how long, what specific bed safety risks and sleep behaviours were

to be monitored, by whom and how they would be documented. The RABS form included some bed related safety risk factors which were divided into two categories. The first was a high risk category for injury or entrapment, and the second, a low risk category for injury or entrapment. However, there was no direction written on the form or in the policy as to actions to be taken if any of the high risk factors were identified. The risk factors included the resident's cognitive status, falls history, ability to independently and safely transfer in and out of bed, risk of climbing over the bed rails, use of bed rails for positioning or support, mobility status, any medical conditions that produced involuntary movements and ability to use the nurse call system. The form did not include many other risk factors identified in the clinical guidance document such as specific sleep behaviours, disorders and patterns, medication use that could cause a change in sleeping patterns or behaviours, perceptual deficits, altered sensations, communication disabilities, pain, continence, if bed rail injuries or entrapment occurred in the past and if the resident could use bed rails safely.

The RABS form included "risk reduction interventions" such as bed in the lowest position, falls arrest mattress, bed alarm, bed rail cover, bolster and other. The assessor was required to circle one or more of the interventions. However, the form was not designed to include what alternatives or "risk reduction interventions" were trialled before applying one or more bed rails and whether the alternative was successful or not.

The Director of Care and a Registered Nurse (RN) reported that all residents were re-assessed following the previous inspection by both registered staff and a personal support worker (PSW) for a minimum of one night for sleeping patterns and bed rail use. The data or information collected by the PSWs from the sleep observations were not available for review and the dates were not documented. A list of specific questions or sleep patterns, behaviours and habits that PSWs may have used to guide their assessments was not available for review.

Resident #102's bed was observed during the inspection, with both rotating assist bed rails in the "guard" position. The rotating assist bed rails were noted to be approximately two feet long and could be rotated and locked into two different positions, a "guard" position (horizontal) or an "assist" position (vertical). The terms were derived from the manufacturer's user guide. The resident's written plan of care identified that the resident was at high risk of bed entrapment, that the resident requested that their left bed rail be "up at all times", (assist position) for bed mobility and/or transfers and the "right bed rail removed as per resident's choice". The RABS form dated December 2016, included that the resident was confused or disoriented, had a history of falls, was able to get in and out

of bed and could mobilize themselves, but did not include that they could use bed rails for positioning (bed mobility). A section on the RABS form included that maintenance was notified via workshub (maintenance system) to remove the right bed rail on a specified date in December 2016. The assessment did not include the selection of any risk reduction interventions, what was trialled to replace the hard bed rail, for how long and whether it was successful or not and whether risks were identified while the resident was in bed with both bed rails applied (whether in the guard or assist position). The assessor concluded that the resident requested the use of the bed rail despite being informed of the safety risks.

Resident #103 was observed during the inspection, transferring themselves to bed using several assistive devices, including one rotating assist bed rail located on their right, which was in the "guard" position. It was apparent that the various assistive devices were quite necessary for the resident's independence to self-transfer. As the resident settled into bed with limited assistance by the PSW, the resident was observed to favour the right side of the bed, near the edge of the mattress. The PSW was asked if the resident had ever been found suspended off the edge of their bed or slid off the bed between their bed rail end and the head board on their right side. The PSW said that to date, they had not, but that it was a concern based on how they slept. The resident's RABS form dated January 2017, included that both bed rails were to be "in use" which was clarified by the PSW to mean in the "guard" position. The RABS form also included that the resident used the bed rails for positioning/support, was unable to transfer safely in and out of bed independently and had involuntary movements. The resident's written plan of care did not include when the bed rails were to be applied, and included that the resident required extensive staff assistance for bed mobility and required one staff member to help resident move about in bed due to several physical limitations. The assessor did not select any risk reduction interventions on the RABS form and selected that the resident requested the choice to use the bed rails. Alternatives to the use of bed rails were not trialled, or a rationale for or against the use of alternatives not documented. The resident had many high risk factors associated with their condition with respect to suspension or bed related injury associated with having the bed rails "in use" after transferring to bed. The concern was raised with the RN and Administrator during the inspection that despite the various risk factors identified by the assessor, appropriate risk interventions were not considered in relation to the resident's medical condition, when bed rails were to be applied and the type of bed rails to be used. The Administrator and RN both acknowledged the concerns and stated that they would re-assess the resident and if necessary, they would provide the resident with a different type of bed rail system.

Resident #104 was observed in bed during the inspection, with both rotating assist bed rails in the "guard" position. The resident's written plan of care identified that only their right side bed rail was to be in the guard position for bed mobility and/or transfers. The resident's bed mobility status was identified as limited, requiring extensive assistance by staff and required assistance in using the bed rail. The resident's RABS form dated January 2017, included information that the resident had some cognitive impairment, was at risk of climbing over the bed rails but did not include that they could not transfer out of bed independently or become easily agitated, as per their written plan of care. The assessment form included, that if the resident was at risk of climbing over the bed rails, they were considered at high risk of bed entrapment or injury. The risk reduction intervention that was selected included "bed in the lowest position". The assessment did not include what was trialled to replace the hard bed rail, for how long and whether it was successful or not and whether risks were identified while the resident was in bed with bed rails applied. The assessor concluded that the resident requested the use of the bed rail despite being informed of the safety risks.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document to identify and mitigate safety risks to residents where bed rails were used 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".***

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**Issued on this 23rd day of March, 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_0012 |
| **Log No. / Registre no:** | 026385-16 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Mar 20, 2017 |
| **Licensee / Titulaire de permis :** | FOYER RICHELIEU WELLAND<br>655 Tanguay Ave, WELLAND, ON, L3B-6A1 |
| **LTC Home / Foyer de SLD :** | FOYER RICHELIEU WELLAND<br>655 TANGUAY AVENUE, WELLAND, ON, L3B-6A1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Sean Keays |

To FOYER RICHELIEU WELLAND, 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_341583_0010, CO #002;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall complete the following:

1. Resident #103 shall be re-assessed immediately in accordance with 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) to determine if their bed rail is required while in bed unsupervised, and if so, if their bed rail type presents any safety risks to the resident while in bed. Any safety risks identified shall be mitigated or interventions implemented to reduce the safety risks.

2. Amend the home's existing forms related to bed rail use and bed safety assessments to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) which is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time, to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
c. the resident while sleeping for a specific period of time, to establish safety risks to the resident after a bed rail has been applied and deemed necessary where an alternative was not successful; and

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. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form(s) and document the assessed results and recommendations for each resident.

5. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form(s). Include in the written plan of care any necessary interventions that are required to mitigate any identified bed safety hazards.

6. Amend the existing policy "Resident Bed Safety" (09-03-01) dated October 31, 2016 related to bed systems so that it will guide an assessor in completing:

a) bed safety evaluations in accordance with Health Canada's guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006"; and
b) resident clinical assessments in accordance with the U.S. F.D.A's document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings".

**Grounds / Motifs :**

1. The licensee did not ensure that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection was previously conducted between May 25 and June 13, 2016, and non-compliance was identified with this section. An order with multiple conditions was issued, one of which included the requirement to develop an interdisciplinary resident assessment to be used to assess all residents who had care directions for the use of bed rails in accordance with 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).

For this follow up inspection, three residents (#102, #103 and #104) 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. It was determined that the staff who participated in the assessments of the residents, where bed rails were used, did not complete or fully assess the residents in accordance with the directions as specified in the clinical guidance document.

According to the licensee's policy #09-03-01 titled "Resident Bed Safety", residents were to be assessed using a form titled "Resident Assessment for Bed Safety (RABS)" upon admission, quarterly, when there was a significant change in their health status and any changes to the resident's bed system. The policy did not include how many nights the resident was to be monitored, both with and without bed rails, whether alternatives were to be trialled and for how long, what specific bed safety risks and sleep behaviours were to be monitored, by whom and how they would be documented. The RABS form included some bed related safety risk factors which were divided into two categories. The first was a high risk category for injury or entrapment, and the second, a low risk category for injury or entrapment. However, there was no direction written on the form or in the policy as to actions to be taken if any of the high risk factors were identified. The risk factors included the resident's cognitive status, falls history, ability to independently and safely transfer in and out of bed, risk of climbing over the bed rails, use of bed rails for positioning or support, mobility status, any medical conditions that produced involuntary movements and ability to use the nurse call system. The form did not include many other risk factors identified in

the clinical guidance document such as specific sleep behaviours, disorders and patterns, medication use that could cause a change in sleeping patterns or behaviours, perceptual deficits, altered sensations, communication disabilities, pain, continence, if bed rail injuries or entrapment occurred in the past and if the resident could use bed rails safely.

The RABS form included "risk reduction interventions" such as bed in the lowest position, falls arrest mattress, bed alarm, bed rail cover, bolster and other. The assessor was required to circle one or more of the interventions. However, the form was not designed to include what alternatives or "risk reduction interventions" were trialled before applying one or more bed rails and whether the alternative was successful or not.

The Director of Care and a Registered Nurse (RN) reported that all residents were re-assessed following the previous inspection by both registered staff and a personal support worker (PSW) for a minimum of one night for sleeping patterns and bed rail use. The data or information collected by the PSWs from the sleep observations were not available for review and the dates were not documented. A list of specific questions or sleep patterns, behaviours and habits that PSWs may have used to guide their assessments was not available for review.

Resident #102's bed was observed during the inspection, with both rotating assist bed rails in the "guard" position. The rotating assist bed rails were noted to be approximately two feet long and could be rotated and locked into two different positions, a "guard" position (horizontal) or an "assist" position (vertical). The terms were derived from the manufacturer's user guide. The resident's written plan of care identified that the resident was at high risk of bed entrapment, that the resident requested that their left bed rail be "up at all times", (assist position) for bed mobility and/or transfers and the "right bed rail removed as per resident's choice". The RABS form dated December 2016, included that the resident was confused or disoriented, had a history of falls, was able to get in and out of bed and could mobilize themselves, but did not include that they could use bed rails for positioning (bed mobility). A section on the RABS form included that maintenance was notified via workshub (maintenance system) to remove the right bed rail on a specified date in December 2016. The assessment did not include the selection of any risk reduction interventions, what was trialled to replace the hard bed rail, for how long and whether it was successful or not and whether risks were identified while the resident was in bed with both bed rails

applied (whether in the guard or assist position). The assessor concluded that the resident requested the use of the bed rail despite being informed of the safety risks.

Resident #103 was observed during the inspection, transferring themselves to bed using several assistive devices, including one rotating assist bed rail located on their right, which was in the "guard" position. It was apparent that the various assistive devices were quite necessary for the resident's independence to self-transfer. As the resident settled into bed with limited assistance by the PSW, the resident was observed to favour the right side of the bed, near the edge of the mattress. The PSW was asked if the resident had ever been found suspended off the edge of their bed or slid off the bed between their bed rail end and the head board on their right side. The PSW said that to date, they had not, but that it was a concern based on how they slept. The resident's RABS form dated January 2017, included that both bed rails were to be "in use" which was clarified by the PSW to mean in the "guard" position. The RABS form also included that the resident used the bed rails for positioning/support, was unable to transfer safely in and out of bed independently and had involuntary movements. The resident's written plan of care did not include when the bed rails were to be applied, and included that the resident required extensive staff assistance for bed mobility and required one staff member to help resident move about in bed due to several physical limitations. The assessor did not select any risk reduction interventions on the RABS form and selected that the resident requested the choice to use the bed rails. Alternatives to the use of bed rails were not trialled, or a rationale for or against the use of alternatives not documented. The resident had many high risk factors associated with their condition with respect to suspension or bed related injury associated with having the bed rails "in use" after transferring to bed. The concern was raised with the RN and Administrator during the inspection that despite the various risk factors identified by the assessor, appropriate risk interventions were not considered in relation to the resident's medical condition, when bed rails were to be applied and the type of bed rails to be used. The Administrator and RN both acknowledged the concerns and stated that they would re-assess the resident and if necessary, they would provide the resident with a different type of bed rail system.

Resident #104 was observed in bed during the inspection, with both rotating assist bed rails in the "guard" position. The resident's written plan of care identified that only their right side bed rail was to be in the guard position for bed

mobility and/or transfers. The resident's bed mobility status was identified as limited, requiring extensive assistance by staff and required assistance in using the bed rail. The resident's RABS form dated January 2017, included information that the resident had some cognitive impairment, was at risk of climbing over the bed rails but did not include that they could not transfer out of bed independently or become easily agitated, as per their written plan of care. The assessment form included, that if the resident was at risk of climbing over the bed rails, they were considered at high risk of bed entrapment or injury. The risk reduction intervention that was selected included "bed in the lowest position". The assessment did not include what was trialled to replace the hard bed rail, for how long and whether it was successful or not and whether risks were identified while the resident was in bed with bed rails applied. The assessor concluded that the resident requested the use of the bed rail despite being informed of the safety risks.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document to identify and mitigate safety risks to residents where bed rails were used 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 O. Regulation 79/10, the scope of the non-compliance is widespread, as none of the residents who used one or more bed rails were 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 noncompliance is on-going. An order was previously issued on July 22, 2016. (120)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 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 20th day of March, 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