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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7
Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Dec 8, 2016	2016_539120_0072	030760-16	Critical Incident System

Licensee/Titulaire de permis

THE CORPORATION OF HALDIMAND COUNTY
45 Munsee Street Box 400 Cayuga ON N0A 1E0

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

GRANDVIEW LODGE / DUNNVILLE
657 LOCK STREET WEST DUNNVILLE ON N1A 1V9

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 Critical Incident System inspection.

This inspection was conducted on the following date(s): November 14, 2016

A critical incident (any incident which involves resident injury and transfer to hospital) report #M532-000023-16 was submitted by the licensee in October 2016.

During the course of the inspection, the inspector(s) spoke with the Director of Care, registered staff, non-registered staff and the Environmental Services Supervisor.

During the course of the inspection, the inspector toured random resident rooms and observed the bed systems, reviewed the licensee's bed safety policies and procedures, bed entrapment audit results and resident clinical records.

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

In October 2016 the licensee reported to the Ministry of Health and Long Term Care that resident #001 sustained an injury in October 2016 related to their bed system. As a result, an inspection was initiated to determine if the licensee's bed safety program was compliant with legislative requirements.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined that it was not fully developed in accordance with the Clinical Guidance document identified below. Several components of the Clinical Guidance document were not incorporated into the assessment process.

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidance Document includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources". Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are

used.

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, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident’s medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this inspection, resident #001 and an additional four residents were randomly selected for review, all of whom were observed to either have one or more bed rails in use or had care plans indicating that they required one or more bed rails as a Personal Assistance Services Device (PASD).

According to the Director of Care (DOC) residents all received an assessment by registered staff and their conclusions were documented on a form titled, "Bed System Assessment". The form, when reviewed, included information about the residents' functional abilities, ability to follow direction, history of falls, pain issues, skin integrity, history of entrapment, whether the bed was evaluated for entrapment, whether the resident or their SDM preferred the use of the bed rails and the names of the staff

involved in the assessment. Other key questions were not included and are discussed below.

The home's procedures titled, "Bedrail Entrapment" dated October 2014, required registered staff to assess the resident for bed rail risk on admission, with any significant change in condition, and following any incident related to safety in bed by using the "Bed Safety Assessment" form.

A) The home's clinical safety assessment process related to bed rails did not include a component related to evaluating the resident's sleep patterns, habits and behaviours while sleeping in bed with or without the application of bed rails. There were no details included in any of the home's procedures as to how the assessment of residents would be conducted. Neither the "Bed System Assessment" form or the procedures included information regarding if/how long residents were to be observed, the dates that they were observed and the specific behaviours that were to be monitored during the observation period.

Resident #001 was admitted to the home in the summer of 2015 and their bed safety assessment was completed on the same date. Bed rails were applied as per the request of a family member before conducting any independent assessment of the resident's sleeping behaviours and habits.

Resident #002 was admitted to the home in the fall of 2016 and their care plan identified that they did not require any bed rails. With the aid of a registered nurse, their bed system assessment could not be located. The resident's bed was observed to have two quarter bed rails elevated on November 14, 2016.

Resident #003 was admitted to the home in the spring of 2009 and their care plan identified that they required both rotating assist rails while in bed. The resident was observed in bed with both of their bed rails in place (guard position). However, with the aid of a registered nurse, their bed system assessment could not be located.

Resident #005 was admitted to the home in the fall of 2016 and their care plan identified that they were independent with transfers. No information was included in their care plan regarding if bed rails were required or not and the bed system assessment form located in the chart was blank.

B) The "Bed System Assessment" form which included a section where the assessor

was to select what alternatives were trialled, did not adequately include what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. The form included nine options, (floor mats, bed alarm, scheduled toileting, low bed, restorative care referral, devices within reach, increased safety checks, decreased time in bed, scheduled toileting). Several of these alternatives are considered accessories (some for falls prevention) and can be applied in conjunction with a bed rail but are not necessarily alternatives to using a bed rail.

For all five residents, the "alternatives" section could not be completed in full. The bed system assessment form did not include an area for staff to document details as to what alternative was implemented in place of the bed rail before it was applied and whether it was successful or not before deciding that a hard bed rail was the safest choice for the resident. It appeared that the assessor(s) had selected the alternatives to be used in conjunction with bed rails as opposed to selecting the “alternative” as a replacement for one or more bed rails.

C) The questions included on the "Bed Safety Assessment" form did not include several key questions related to whether bed rails were used in the past and why, the purpose of the device (whether a restraint or a PASD) once assessed, cognition, medication use, sleeping behaviours and toileting habits and any involuntary or spasmodic body movements, Once the assessor checked off the boxes that were relevant to the resident, no further guidance was provided to assist the assessor in making any decisions as to whether the resident was at any risk for entrapment or injury if bed rails were to be applied.

Resident #001, who was not independently observed for sleep patterns or behaviours before two bed rails were applied, fell from bed four times over a three month period in 2015 and fell from bed three times in 2016 before the incident in October 2016. The resident's care plan identified that the resident "used two bed rails to assist staff to reposition and turn them in bed", had cognition deficits, required full extensive assistance with most care activities such as toileting, bathing, dressing and transfers. Notations made by registered staff in 2015 and 2016 after each fall identified that the resident was confused, tired, lethargic, forgot that they could not walk independently and was a vivid dreamer. A post fall assessment was completed in each case and accessories added to the bed to monitor the resident. However, no clinical bed system re-assessment was completed after any of the falls prior to October 2016. The resident's sleep patterns and behaviour coupled with their cognitive state were risk factors for potential bed system injury and were not considered until the latest fall in October 2016.

The bed rails were removed two days after the fall.

Both the DOC and a registered nurse who participated in the completion of the assessment forms reported that they felt pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.
[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 8th day of December, 2016

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 :	2016_539120_0072
Log No. / Registre no:	030760-16
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Dec 8, 2016
Licensee / Titulaire de permis :	THE CORPORATION OF HALDIMAND COUNTY 45 Munsee Street, Box 400, Cayuga, ON, N0A-1E0
LTC Home / Foyer de SLD :	GRANDVIEW LODGE / DUNNVILLE 657 LOCK STREET WEST, DUNNVILLE, ON, N1A-1V9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Joanne Jackson

To THE CORPORATION OF HALDIMAND COUNTY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing "Bed Safety Assessment" form so that it includes 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) 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". 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.

2. 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. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

3. Develop an education and information package for staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.

Grounds / Motifs :

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

In October 2016 the licensee reported to the Ministry of Health and Long Term Care that resident #001 sustained an injury in October 2016 related to their bed

system. As a result, an inspection was initiated to determine if the licensee's bed safety program was compliant with legislative requirements.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined that it was not fully developed in accordance with the Clinical Guidance document identified below. Several components of the Clinical Guidance document were not incorporated into the assessment process.

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cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this inspection, resident #001 and an additional four residents were randomly selected for review, all of whom were observed to either have one or more bed rails in use or had care plans indicating that they required one or more bed rails as a Personal Assistance Services Device (PASD).

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safety assessment was completed on the same date. Bed rails were applied as per the request of a family member before conducting any independent assessment of the resident's sleeping behaviours and habits.

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Resident #005 was admitted to the home in the fall of 2016 and their care plan identified that they were independent with transfers. No information was included in their care plan regarding if bed rails were required or not and the bed system assessment form located in the chart was blank.

B) The "Bed System Assessment" form which included a section where the assessor was to select what alternatives were trialled, did not adequately include what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. The form included nine options, (floor mats, bed alarm, scheduled toileting, low bed, restorative care referral, devices within reach, increased safety checks, decreased time in bed, scheduled toileting). Several of these alternatives are considered accessories (some for falls prevention) and can be applied in conjunction with a bed rail but are not necessarily alternatives to using a bed rail.

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C) The questions included on the "Bed Safety Assessment" form did not include

several key questions related to whether bed rails were used in the past and why, the purpose of the device (whether a restraint or a PASD) once assessed, cognition, medication use, sleeping behaviours and toileting habits and any involuntary or spasmodic body movements, Once the assessor checked off the boxes that were relevant to the resident, no further guidance was provided to assist the assessor in making any decisions as to whether the resident was at any risk for entrapment or injury if bed rails were to be applied.

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Both the DOC and a registered nurse who participated in the completion of the assessment forms reported that they felt pressured by certain SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.

This Order is based upon the above non-compliance and three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 3 (actual harm), the scope is 2 (pattern - more than one resident has not been assessed in accordance with prevailing practices) and the compliance history is 3 (non-compliance previously issued in the same area). A VPC was previously issued

on December 2, 2014.
(120)

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

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 8th day of December, 2016

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