Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue 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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
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Bureau régional de services d'Ottawa
347 rue Preston bureau 420
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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 29, 2019	2018_765541_0019 (A3)	008072-18, 009364-18, 021950-18, 024848-18, 027465-18, 027920-18, 029049-18	Complaint

Licensee/Titulaire de permis

The Corporation of the County of Lanark
c/o Lanark Lodge 115 Christie Lake Road PERTH ON K7H 3C6

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

Lanark Lodge
115 Christie Lake Road, R. R. #4, Lot 27, Concession 2 PERTH ON K7H 3C6

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

Amended by AMBER LAM (541) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date was extended to allow for delivery and installation of the required equipment.

Issued on this 29th day of April, 2019 (A3)

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

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

Amended by AMBER LAM (541) - (A3)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 14-15, 19-22, 28 and 30, 2018.

The following logs were completed during this inspection:

Log #008072-18 (IL-56551-OT) - A complaint regarding resident care

Log #009364-18 (IL-5682-OT) - A complaint regarding resident care

Log #024848-18 (IL-59797-OT) - A complaint regarding resident care

Log #029049-18 - A complaint regarding resident care

Log #021950-18 - A complaint regarding resident care

Log #027465-18 (Critical Incident #M548-000032-18) - An incident regarding resident care

Log #027920-18 (Critical Incident #M548-000033-18) - An incident causing injury to a resident

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, the Director of Care, Registered Nurses, Registered Practical Nurses, Health Care Aides, Maintenance staff, residents and family. In addition, the inspector reviewed resident health care records, observed residents' bed systems, reviewed the home's complaint records and observed staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
4 WN(s)
1 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	Légende 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 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 and (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In August, 2012, 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 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 includes the titles of two additional companion documents. 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, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used.

During the inspection it was noted that residents #001, #002 and #006 have what the home refers to as “bed helpers” on their beds.
Resident #001 and #002’s bed rail assessments completed on a specified date were reviewed. The assessment for resident #001 indicated the resident had one bed rail on the bed which was removed at the time of the assessment (no reason provided) and one helper rail was in place. The assessment for resident #002 indicated that bed rails are not to be used, but that the resident uses a bed helper.

The manufacturer’s instructions were obtained which indicated the “bed helpers” are called M-Rail home bed assist handles. There are three openings in the rail which would be considered zones of entrapment when attached to the beds.

The home also has newer bed systems which have a “universal three position pivot assist rail”.

On November 19, 2018, Inspector #541 spoke with the Director of Care (DOC) who indicated the maintenance manager is responsible for performing the assessments of bed systems for potential zones of entrapment. The DOC further stated that the home does not consider the M-Rails to be bed rails.

On November 19, 2018, Inspector #541 interviewed maintenance manager #103 regarding the steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. Maintenance manager #103 indicated only a few of the “M-Rail home bed assist handles” were assessed on the bed systems. Once it was found that there was no risk of entrapment on the tested bed systems, the rest of the bed systems were not assessed for zones of entrapment. The evaluation of the bed systems that were completed were not documented.

When asked how many bed systems have the M-Rail home bed assist handles, maintenance manager #103 stated this is not tracked. Inspector #541 noted that in addition to the three residents' mentioned above, there were seven other bed systems on one unit that had the M-Rail home bed assist handles on their bed.

When asked about the newer bed systems with the "universal three position pivot assist rail", maintenance manager #103 indicated none of these bed systems or potential zones of entrapment were tested as the representative from the company providing the bed systems indicated that the beds were all designed to pass entrapment zones.

The licensee has failed to ensure that where bed rails were used, the resident's bed system was evaluated according to evidence-based practices and that steps were taken to prevent resident entrapment. [s. 15. (1) (b)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure the care set out in resident #004's plan of care was provided to the resident as specified in the plan.

A complaint was received by the MOHLTC from resident #004's Substitute Decision Maker (SDM). The complainant indicated being informed by the home that the resident needed specialized care and the home was requesting consent for the same. The complainant stated that the specialized care was consented to when resident #004 was admitted and was under the assumption this was being provided.

Inspector #541 reviewed resident #004's progress notes. On a specified date it was noted by ADOC #105 that resident #004 required specialized care and the home was requesting consent from the resident's SDM for the care. Resident #004's SDM informed ADOC #105 that consent had already been provided.

Inspector reviewed resident #004's chart and obtained a document signed on admission by resident #004's SDM which indicated the SDM consented to the specialized care as needed, approximately every 6 weeks.

Upon review of resident #004's progress notes related to the specialized care from admission to the date of inspection, it was noted resident #004 was receiving regular specialized care by a specialist approximately every 6 weeks until a specified date. Resident #004 then received the specialized care 4 times over a 1 year time period. On the specified date when the home requested consent from resident #004's SDM for the specialized care, the resident was noted to have signs indicating the specialized care had not been provided as specified in the resident's plan of care.

Inspector #541 interviewed DOC #101 on November 22, 2018 regarding the specialized care services at the home. DOC #101 indicated the home was having issues with the care being provided by their previous care provider and has since sought out a new provider.

Inspector #541 interviewed the office manager #106 who provided the inspector with documentation to reflect that resident #004's SDM was only charged for the specialized care that was provided to the resident.

The licensee failed to ensure that resident #004 received specialized care as

specified in the plan of care. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee has failed to use bed rails in accordance with the manufacturer's instructions.

During the inspection it was noted that residents #001, #002 and #006 have what the home refers to as “bed helpers” on their beds. The manufacturer’s instructions were obtained which indicated the “bed helpers” are called M-Rail home bed assist handles.

These instructions indicated the following regarding use of the rails:
- "It is very important that the M-Rail is not attached to any part of a Care, Institutional or Hospital bed that can move or be adjusted, and it is very important that the M-Rail attachment straps are not touching any part of the bed that moves."
- “For added safety, we recommend installing two M-Rails, one on each side of the bed, to assist with keeping the mattress in place, with no gaps”.

Inspector #541 noted during the inspection that the M-Rails for residents #001, #002, #006 and the seven observed on one unit, were all attached to the head of the bedframe, all of which moved. An interview with DOC #101 on November 20, 2018 confirmed that all of the M-Rails used in the home are attached to beds which move. Inspector #541 interviewed ADOC #105 on November 20, 2018 who indicated being told that having two M-Rails on the bed system would be considered a restraint, therefore no resident has two bed helpers on their bed system. [s. 23.]

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the licensee kept a documented record in the home that includes:
(a) the nature of each verbal or written complaint
(b) the date the complaint was received
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required
(d) the final resolution, if any
(e) every date on which any response was provided to the complainant and a description of the response, and
(f) any response made by the complainant

A complaint was submitted to the Ministry of Health and Long-Term Care (MOHLTC) which indicated, among other concerns, that the home has not informed the complainant of action taken as a result of concerns they had brought forward to the home in 2018.

In 2018, the complainant brought forward concerns in writing to the home related to high temperatures in the home, which were effecting the health of residents. These concerns were inspected by the MOHTLC (Inspection #2018_761178_0013). When the complaint was received, the complainant indicated the home had made changes to some of the windows of the home in order to better manage the temperature in hot weather, however the home did not inform the complainant, who had initially brought the issue forward.

Inspector #541 spoke with DOC #101 on November 20, 2018 and requested all documentation the home had related to complaints received from the complainant. There was no documented record kept at the home indicating that concerns from this complainant were brought forward regarding the temperature in the home and no documentation regarding any responses provided to the complainants or action taken by the home as result of the complaints.

During an interview, the DOC indicated the any documentation related to the air temperatures would have been taken by the previous administrator.

The licensee failed to keep a documented record of a complaint brought forward regarding high temperatures in the home, the date the complaint was received, the type of action taken to resolve the complaint, the final resolution (if any), every date on which any response was provided to the complainant and any response made by the complainant. [s. 101. (2)]

2. The licensee failed to ensure the documented record of complaints received is reviewed and analyzed for trends at least quarterly.

On November 21, 2018, Inspector #541 interviewed DOC #101 who stated the home has not completed any analysis of the complaints received this year (2018) due to the home having other concerns that had to be dealt with. [s. 101. (3)]

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Issued on this 29th day of April, 2019 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMBER LAM (541) - (A3)
Inspection No. / No de l'inspection :	2018_765541_0019 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	008072-18, 009364-18, 021950-18, 024848-18, 027465-18, 027920-18, 029049-18 (A3)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 29, 2019(A3)
Licensee / Titulaire de permis :	The Corporation of the County of Lanark c/o Lanark Lodge, 115 Christie Lake Road, PERTH, ON, K7H-3C6
LTC Home / Foyer de SLD :	Lanark Lodge 115 Christie Lake Road, R. R. #4, Lot 27, Concession 2, PERTH, ON, K7H-3C6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennie Bingley

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To The Corporation of the County of Lanark, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 must be compliant with O. Reg. 79/10, s. 15 (1). Specifically the licensee shall:

1) Ensure that bed rail use for resident #001, #002, #006 and any other resident is assessed and implemented in full accordance with 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)". This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b.) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Ensure that steps are taken and documented to prevent resident entrapment for residents #001, #002, #006 and any other resident, taking into consideration all potential zones of entrapment.

Grounds / Motifs :

(A1)
1. The licensee has failed to 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 and (b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In August, 2012, 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 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 includes the titles of two additional companion documents. 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, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used.

During the inspection it was noted that residents #001, #002 and #006 have what the home refers to as "bed helpers" on their beds.
Resident #001 and #002's bed rail assessments completed August 28, 2018 were reviewed. The assessment for resident #001 indicated the resident had one bed rail on the bed which was removed at the time of the assessment (no reason provided) and one helper rail was in place. The assessment for resident #002 indicated that bed rails are not to be used, but that the resident uses a bed helper.

The manufacturer's instructions were obtained which indicated the "bed helpers" are called M-Rail home bed assist handles. There are three openings in the rail which would be considered zones of entrapment when attached to the beds.

The home also has newer bed systems which have a "universal three position pivot assist rail".

On November 19, 2018, Inspector #541 spoke with the Director of Care (DOC) who indicated the maintenance manager is responsible for performing the assessments of bed systems for potential zones of entrapment. The DOC further stated that the home does not consider the M-Rails to be bed rails.

On November 19, 2018, Inspector #541 interviewed maintenance manager #103 regarding the steps taken to prevent resident entrapment, taking into consideration all potential zones of entrapment. Maintenance manager #103 indicated only a few of the "M-Rail home bed assist handles" were assessed on the bed systems. Once it was found that there was no risk of entrapment on the tested bed systems, the rest of the bed systems were not assessed for zones of entrapment. The evaluation of the bed systems that were completed were not documented.

When asked how many bed systems have the M-Rail home bed assist handles, maintenance manager #103 stated this is not tracked. Inspector #541 noted that in addition to the three residents' mentioned above, there were seven other bed systems on one unit that had the M-Rail home bed assist handles on their bed.

When asked about the newer bed systems with the "universal three position pivot assist rail", maintenance manager #103 indicated none of these bed systems or potential zones of entrapment were tested as the representative from the company providing the bed systems indicated that the beds were all designed to pass entrapment zones.

The licensee has failed to ensure that where bed rails were used, the resident's bed system was evaluated according to evidence-based practices and that steps were taken to prevent resident entrapment.

In addition to this compliance order, a written notification (WN) was issued under O.

Reg 79/10 s. 23 for failing to ensure that staff use bed rails in the home in accordance with manufacturers' instructions. (Refer to WN #2)

The decision to issue a compliance order was based on the following:
- The risk determined to be level 2 - minimal harm or potential for actual harm.
- The scope was widespread as 3 out of 3 residents reviewed did not have entrapment assessments completed on their bed systems.
- The compliance history was level 2 - 1 or more unrelated non-compliance in the past 36 months. (541)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 15, 2019(A3)

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 29th day of April, 2019 (A3)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by AMBER LAM (541) - (A3)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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