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 # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 8, 2018 | 2017_547591_0017 | 008636-17, 008638-17, 008639-17 | Follow up |

### Licensee/Titulaire de permis

Mississauga Long Term Care Facility Inc.
26 Peter Street North MISSISSAUGA ON L5H 2G7

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

Mississauga Long Term Care Facility
26 Peter Street North MISSISSAUGA ON L5H 2G7

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

NATASHA JONES (591)

### 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): October 5, 2017.**

**The following Follow-up inspections were completed in relation to RQI inspection report #2017-561583-0006, log #05288-17, completed April 24, 2017:**
**- Order #001 - O. Reg 79/10, s.15.(1) - related to bed rails,**
**- Order #002 - O. Reg 79/10, s. 48.(2) - related to required programs, and**
**- Order #003 - LTCHA, 2007 S.O 2007, c.8, s.6.(11) - related to plan of care.**

**During the course of the inspection, the inspector(s) spoke with the Director of Care (DOC), Food Services Supervisor (FSS), registered staff and personal support workers (PSWs).**

**During the course of the inspection, the inspector interviewed staff and residents, observed the provision of care and reviewed clinical health records, policies, procedures and practices.**

**The following Inspection Protocols were used during this inspection:**
**Safe and Secure Home**
**Skin and Wound Care**

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

**The following previously issued Order(s) were found to be in compliance at the time of this inspection:**
**Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:**

| REQUIREMENT/ EXIGENCE | TYPE OF ACTION/ GENRE DE MESURE | INSPECTION # / NO DE L'INSPECTION | INSPECTOR ID #/ NO DE L'INSPECTEUR |
|---|---|---|---|
| LTCHA, 2007 s. 6. (11) | CO #003 | 2017_561583_0006 | 591 |

| 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. 48. Required programs**

**Findings/Faits saillants :**

1. The licensee failed to ensure that each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

A review of the home's "Falls Prevention and Management Program", updated July 19, 2017, included a document titled "Appendix D: Post Falls Assessment Tool". The tool was a clinically appropriate post fall assessment instrument for assessing and reassessing residents who sustained a fall. On July 24, 2017, the registered staff were directed by the DOC to implement the new "Post Fall Assessment Tool" immediately. No record of staff completion of training on the revised "Falls Prevention and Management Program" or new "Post Fall assessment tool" were produced.
In interviews, registered staff #100 and #101 confirmed a memo was placed in the nursing station which directed them to implement the new post fall assessment tool immediately; however, training on the revised program and new tool had not been provided to the staff.

In an interview, the DOC could not confirm that the training as mentioned above was delivered to all registered staff. [s. 48. (2)]

***Additional Required Actions:***

***CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".***

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**WN #2: 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 failed to ensure where bed rails were used, the resident was assessed, and his or her bed system was evaluated in accordance with evidence based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident where bed rails are used, or that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Prevailing practices were identified in a document titled "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), where recommendations were 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.

i. To guide the assessor, a series of questions would be answered to determine whether the bedrail(s) are safe devices for residents while in bed (when fully awake and while they are asleep).

ii. 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.

iii. 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.

iv. 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 substitute decision maker (SDM) about the necessity and safety of a bed rail (medical device).

v. 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.

B) A review of the home's policy, titled "Use of a PASD"; last revised February 13, 2017, the home's "Bed Safety Program", dated November 29, 2012, and the home's current electronic "PASD Assessment", revealed the documents were not revised to include evidence-based or prevailing practices to minimize resident risk.

The electronic PASD assessment did not include:

- a series of questions to determine whether the bedrails were safe devices for residents while in bed,
- where bed rails were considered for transferring and bed mobility, discussions held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary,
- questions to be considered including 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 substitute decision maker (SDM) about the necessity and safety of a bed rail (medical device), and,
- documentation of the final conclusion 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.
Completed PASD electronic assessments for resident #002, dated May 2017, and for resident #003, dated September 2017, were reviewed and did not include evidence-based or prevailing practices to minimize resident risk as previously mentioned.
In an interview, the Director of Care (DOC) confirmed the current PASD assessment used for residents in the home did not include evidence-based or prevailing practices to minimize resident risk.

C) A review of the home's "Facility Entrapment Inspection Sheet", dated May 31, 2017 and July 10, 2017 indicated that all of the bed systems in the home were re-evaluated, however; the documentation did not include the type of mattress and unique mattress identifier, bed rail type, or bed frame serial number. In an interview, the DOC confirmed that the documentation was not complete.

D) A review of the home's electronic personal assistive safety device (PASD) assessments for resident's #002, #003 and #004 who used one or more bed rails, revealed the tool was not revised to include all relevant questions as per prevailing practice. In an interview, the DOC confirmed the assessment tool revisions were in progress, however; the registered staff continued to use the existing tool which did not meet the requirements as per prevailing practices.

E) A review of the written plans of care for residents #002, #003, and #004 indicated the plans had not been updated related to bed safety hazards as they had not been re-assessed using a revised bed rail use and bed safety assessment tool based on prevailing practices. This was confirmed in an interview by the DOC.

F) In interviews, registered staff #100 and #101 confirmed they had not received education on a revised bed rail assessment tool or the home's requirements for bed safety assessments. The staff further confirmed they continued to use the current electronic PASD assessment, which was not based on prevailing practices. In an interview, the DOC confirmed staff had not been educated as the revised bed rail use and bed safety assessment tool was still in progress and had not yet been implemented. They further confirmed the staff continued to use the current assessment tool which was not based on prevailing practices.

The home did not ensure where bed rails were used, the resident was assessed, and his or her bed system was evaluated in accordance with evidence based practices or

prevailing practices, to minimize risk to the residents. [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 7th day of February, 2018**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | NATASHA JONES (591) |
| **Inspection No. / No de l'inspection :** | 2017_547591_0017 |
| **Log No. / No de registre :** | 008636-17, 008638-17, 008639-17 |
| **Type of Inspection / Genre d'inspection:** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Jan 8, 2018 |
| **Licensee / Titulaire de permis :** | Mississauga Long Term Care Facility Inc.<br>26 Peter Street North, MISSISSAUGA, ON, L5H-2G7 |
| **LTC Home / Foyer de SLD :** | Mississauga Long Term Care Facility<br>26 Peter Street North, MISSISSAUGA, ON, L5H-2G7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Novak Bajin |

To Mississauga Long Term Care Facility Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_561583_0006, CO #001;

**Pursuant to / Aux termes de :**

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

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

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

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

**Order / Ordre :**

The licensee shall complete the following:

1. Develop and implement an assessment tool 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) 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.

2. Re-evaluate all of the bed systems in the home in accordance with Health Canada Guidelines titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2006" and document the results. At a minimum, documentation shall include type of mattress and unique mattress identifier, bed rail type, bed frame serial number, date evaluated, name of evaluator, zones tested, issues identified and follow up action taken if necessary.

3. An interdisciplinary team shall assess all residents who use one or more bed rails using a clinically appropriate bed safety assessment tool and document the assessed results and recommendations for each resident.

4. Update the written plan of care for those residents who require bed rails which have been identified after re-assessing each resident using a clinically appropriate bed safety assessment tool. Include in the written plan of care any necessary accessories that are required to mitigate any identified bed safety hazards.

5. Educate the registered nursing staff on the clinically appropriate bed rail assessment tool and the home's requirements for bed safety assessment.

**Grounds / Motifs :**

1. This Order is being re-issued based on evidence supporting that the licensee failed to complete the requirements as outlined in the order #001, issued in the 2016 Resident Quality Inspection #2017_561583_0006. The compliance date for the order was August 31, 2017.

The licensee failed to ensure where bed rails were used, the resident was

assessed and his or her bed system was evaluated in accordance with evidence based practices and, if there were none, in accordance with prevailing practices, to minimize risk to the resident where bed rails are used, or that steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A) Prevailing practices were identified in a document titled "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), where recommendations were 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.

i. To guide the assessor, a series of questions would be answered to determine whether the bedrail(s) are safe devices for residents while in bed (when fully awake and while they are asleep).

ii. 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.

iii. 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.

iv. 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 substitute decision maker (SDM) about the necessity and safety of a bed rail (medical device).

v. 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.

B) A review of the home's policy, titled "Use of a PASD"; last revised February 13, 2017, the home's "Bed Safety Program", dated November 29, 2012, and the home's current electronic "PASD Assessment", revealed the documents were not revised to include evidence-based or prevailing practices to minimize resident risk.

The electronic PASD assessment did not include:
- a series of questions to determine whether the bedrails were safe devices for residents while in bed,
- where bed rails were considered for transferring and bed mobility, discussions held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary,
- questions to be considered including 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 substitute decision maker (SDM) about the necessity and safety of a bed rail (medical device), and,
- documentation of the final conclusion 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.
Completed PASD electronic assessments for resident #002, dated May 2017, and for resident #003, dated September 2017, were reviewed and did not include evidence-based or prevailing practices to minimize resident risk as previously mentioned.
In an interview, the Director of Care (DOC) confirmed the current PASD assessment used for residents in the home did not include evidence-based or prevailing practices to minimize resident risk.

C) A review of the home's "Facility Entrapment Inspection Sheet", dated May 31, 2017 and July 10, 2017 indicated that all of the bed systems in the home were re-evaluated, however; the documentation did not include the type of mattress and unique mattress identifier, bed rail type, or bed frame serial number. In an interview, the DOC confirmed that the documentation was not complete.

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E) A review of the written plans of care for residents #002, #003, and #004 indicated the plans had not been updated related to bed safety hazards as they had not been re-assessed using a revised bed rail use and bed safety assessment tool based on prevailing practices. This was confirmed in an interview by the DOC.

F) In interviews, registered staff #100 and #101 confirmed they had not received education on a revised bed rail assessment tool or the home's requirements for bed safety assessments. The staff further confirmed they continued to use the current electronic PASD assessment, which was not based on prevailing practices. In an interview, the DOC confirmed staff had not been educated as the revised bed rail use and bed safety assessment tool was still in progress and had not yet been implemented. They further confirmed the staff continued to use the current assessment tool which was not based on prevailing practices.

The home did not ensure where bed rails were used, the resident was assessed and his or her bed system was evaluated in accordance with evidence based practices or prevailing practices, to minimize risk to the residents.
(591)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 15, 2018

**Order # / Ordre no :** 002

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_561583_0006, CO #002;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 48. (2) Each program must, in addition to meeting the requirements set out in section 30,
(a) provide for screening protocols; and
(b) provide for assessment and reassessment instruments. O. Reg. 79/10, s. 48 (2).

**Order / Ordre :**

The licensee shall complete the following:

1.Ensure all registered staff receive education on the revised Falls Management Program, including training on a clinically appropriate assessment instrument and any other post fall management monitoring required.

2.Ensure a documented record is kept of the above, including the date the training was provided and the content of the training.

3.Develop, implement and maintain a record of an auditing process to monitor and ensure the Falls Management Program is being followed by staff, and that residents are assessed post fall using a clinically appropriate assessment instrument when required.

**Grounds / Motifs :**

1. This Order is being re-issued based on evidence supporting that the licensee failed to complete the requirements as outlined in the order #002, issued in the 2016 Resident Quality Inspection #2017_561583_0006. The compliance date for the order was July 31, 2017.

The licensee failed to ensure that each program must, in addition to meeting the requirements set out in section 30, (a) provide for screening protocols; and (b) provide for assessment and reassessment instruments.

A review of the home's "Falls Prevention and Management Program", updated July 19, 2017, included a document titled "Appendix D: Post Falls Assessment Tool". The tool was a clinically appropriate post fall assessment instrument for assessing and reassessing residents who sustained a fall. On July 24, 2017, the registered staff were directed by the DOC to implement the new "Post Fall Assessment Tool" immediately. No record of staff completion of training on the revised "Falls Prevention and Management Program" or new "Post Fall assessment tool" were produced.
In interviews, registered staff #100 and #101 confirmed a memo was placed in the nursing station which directed them to implement the new post fall assessment tool immediately; however, training on the revised program and new tool had not been provided to the staff.

In an interview, the DOC could not confirm that the training as mentioned above was delivered to all registered staff. (591)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 15, 2018

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

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

La demande écrite doit comporter ce qui suit :

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

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON  M5S 2T5

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416 327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this 8th day of January, 2018**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Natasha Jones

**Service Area Office /**
**Bureau régional de services :** Hamilton Service Area Office