Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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347 rue Preston bureau 420
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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 19, 2020	2019_617148_0027 (A2)	011715-19, 012951-19, 013120-19	Critical Incident System

Licensee/Titulaire de permis

The Religious Hospitallers of St. Joseph of Cornwall, Ontario
14 York St CORNWALL ON K6J 5T2

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

St. Joseph's Continuing Care Centre
14 York Street CORNWALL ON K6J 5T2

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

Amended by EMILY BROOKS (732) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Due to the current emergency orders in place amid the Coronavirus pandemic, we will be extending the compliance order #001 issued under O.Reg 79/10, s. 15 from inspection report #2019_617148_0027 to October 31, 2020.

Issued on this 19th day of June, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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14 York Street CORNWALL ON K6J 5T2

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

Amended by EMILY BROOKS (732) - (A2)

Amended 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): September 9-11, 13 and September 16-18, 2019.

This inspection included three critical incident reports (CIR): CIR #C565-000015-19 (Log 012951-19) related to resident to resident physical abuse; CIR #C565-000014-19 (Log 011715-19) related to an incident for which an identified resident was sent to hospital which resulted in a significant change in health status; and CIR #C565-000016-19 (Log 013120-19) related to an incident for which an identified resident was sent to hospital which resulted in a significant change in health status.

During the course of the inspection, the inspector(s) spoke with the Executive Director, Chief Nursing Executive, Nursing Care Coordinator, Director of Therapeutic Services, Director of Support Services, Nursing Administrative Assistant, Registered Nurses, Registered Practical Nurses, Personal Support Workers (PSW), Occupational Therapist and residents.

The Inspector reviewed health care records of the identified residents and documents related to the evaluation of bed systems. In addition the Inspector observed the resident care environment including bed systems, and resident to resident interactions.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

During the course of the original 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	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 :

The licensee failed to ensure that where bed rails are used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

In relation to evidence based and prevailing practices:
In August, 2012, the Ministry of Health and Long-Term Care (MOHLTC) 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 referenced companion documents 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 a clinical practice guideline, 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. The other companion document is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006, FDA".

A critical incident report (CIR) was submitted to the Director describing that resident #003 had fallen from bed on a specified date. The CIR, health care record and interviews with staff indicated that the resident was reaching for personal items that were at the bed side and subsequently fell from the bed. At the time of the fall the resident had two half bed rails in use at the head of bed. As a result of the fall the resident sustained an injury.

Residents #003, #004, #005, #006, #007, #008, #009 and #010 were observed during the inspection to have bed rails in use. The following is a summary of the health care record review, observations and staff interviews related to the use of bed rails for the identified residents:

Resident #003 – Was observed with two half rails in use at the head of bed. On the day of admission the use of bed rails were included in the plan of care. PSW #103 reported that resident #003 may hold on to the rails during transfers to and from the bed. The plan of care indicated that the resident was at fall risk with interventions including two bed rails at the head of bed. The resident had varied needs for bed mobility and extensive assist for transfers.

Resident #004 – Was observed with two half rails in use at the head of bed. When interviewed the resident indicated that the rails have been on the bed as long as the resident has resided in the room. The resident reported that the rails are not used for any purpose. PSW #107 reported that resident #004 rarely uses the rails and is independent for transfers and bed mobility. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; may use the grab rails for assistance with turning and repositioning.

Resident #005 – Was observed with two half rails in use at the head of bed. When interviewed the resident indicated that at times the resident will sometimes hold

the rails when getting out of bed. PSW #107 reported that resident #005 does not use the rails for any purpose. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; was independent for bed mobility and transfers.

Resident #006 – Was observed with three half rails in use, two at the head of bed and one near the foot of the bed. When interviewed the resident indicated that the rails are to keep the resident from falling out of the bed. PSW #107 reported that resident #006 does not use the rails for any clinical purpose but rather the resident prefers to have them in use. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the HOB; limited assistance with bed mobility and transfers.

Resident #007 – Was observed with three half rails in use, two at the head of bed and one near the foot of the bed. PSW #112 reported that resident #007 will use the rails for bed mobility. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; extensive assistance with bed mobility.

Resident #008 – Was observed with two half rails in use at the head of bed. PSW #112 reported that resident #008 does not use the bed rails. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; was independent for bed mobility and transfers.

Resident #009 – Was observed with two half rails in use at the head of bed. PSW #112 reported that resident #009 may use the rails for bed mobility or to reposition. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; varied assistance needed for bed mobility and transfers.

Resident #010 - Was observed with two half rails in use at the head of bed. PSW #112 reported that resident #010 may use the rails during transfers. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; was extensive to total assistance for bed mobility and transfers.

The Director of Therapeutic Services was identified as the lead for the bed rail program in the home. During an interview with the Director of Support Services and the Director of Therapeutic Services on September 11, 2019, it was identified

that all bed systems in the home are manufactured by Styker and that all beds have bed rails in use.

In review of the health care records for the identified eight residents, no resident assessment or risk benefit assessment had been completed with regards to the use of bed rails and risk of entrapment. It was reported by the Director of Therapeutic Services that the home is working towards implementing a policy related to resident assessment of bed rails, but that it is not in place at this time. The Director of Therapeutic Services reported that in the interim, resident are referred to the Occupational Therapist (OT) when nursing staff identify the need. In the matter of the identified residents, no assessment by OT had been completed as it relates to the use of bed rails or entrapment risk.

Observations of the bed rails in use for the eight identified residents, determined the use of a curved rail, potentially impacting the entrapment risk at Zone 4. The most recent bed evaluations completed by the Director of Therapeutic Services and the Director of Support Services, indicated that Zone 4 passed in February 2018 and June 2019. On September 11, 2019, a demonstration of testing was conducted by the Director of Therapeutic Services and the Director of Support Services. The Director of Support Services assembled the cone and cylinder tool and conducted the initial tests. Initial tests were done prior to the mattress being pushed away from the rail being tested and the cone not at the edge of the mattress, this resulted in a fail of Zone 4. After discussion, the Inspector indicated the need to push the mattress away from the rail and it was identified that the cone was to be at the edge of the mattress. After making adjustments to the position of the mattress and cone, subsequent tests provided for a failure of Zone 4 as the rail touched at the line or just over the line into the red area of the cylinder.

In this way, the licensee failed to ensure that where bed rails are used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Additional Required Actions:

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

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 19th day of June, 2020 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by EMILY BROOKS (732) - (A2)
Inspection No. / No de l'inspection :	2019_617148_0027 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	011715-19, 012951-19, 013120-19 (A2)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 19, 2020(A2)
Licensee / Titulaire de permis :	The Religious Hospitallers of St. Joseph of Cornwall, Ontario 14 York St, CORNWALL, ON, K6J-5T2
LTC Home / Foyer de SLD :	St. Joseph's Continuing Care Centre 14 York Street, CORNWALL, ON, K6J-5T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Gizanne Lafrance-Allaire

Ontario

Ministry of Long-Term Care

Ministère 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 Religious Hospitallers of St. Joseph of Cornwall, Ontario, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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 # / No d'ordre: 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 :

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

The licensee must be compliant with O. Reg. 79/10, s. 15 (1)

Specifically the licensee must:

1. Ensure that the bed system for resident #003, and any other resident where bed rails are in use, are evaluated in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document), with specific consideration to zone 4. The zone specific test results are to be documented;

2. Take immediate corrective action should any bed system not meet dimensional guidelines outlined in the HC guidance document. Consider the information outlined in the prevailing practices document "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment (FDA, 2006). Specifically address the potential risk of zone 4 entrapment, as needed;

3. Establish and implement a process for ensuring that all residents with bed rails are assessed in accordance with the 2003 FDA clinical guidance document, by the interdisciplinary team. This includes but is not limited to a documented individual resident assessment and risk benefit assessment.

4. Approval of the use of bed rails for an individual resident and rational, along with the identification of why other care interventions are not appropriate or not effective and the mitigation of any identified risk(s), is to be clearly documented.

5. Update the written plan of care based on the resident's assessment by the interdisciplinary team. When bed rails are in use, include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards resulting from the bed system evaluations.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails are used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-

based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Specifically, the licensee failed to ensure that resident #003, who was observed to have bed rails in use, was provided with a resident assessment and resident risk benefit assessment related to the use of bed rails and entrapment risk. Upon further inspection it was confirmed that at least seven other residents, with bed rails in use, did not have a resident assessment and resident risk benefit assessment related to the use of bed rails and entrapment risk. Additionally, it was demonstrated that the bed evaluations previously conducted may not have been done in accordance with evidence based practices whereby a failure at zone 4 has not been detected.

In relation to evidence based and prevailing practices:
In August, 2012, the Ministry of Health and Long-Term Care (MOHLTC) 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 referenced companion documents 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 a clinical practice guideline, 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.

The other companion document is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006, FDA".

A critical incident report (CIR) was submitted to the Director describing that resident #003 had fallen from bed on a specified date. The CIR, health care record and interviews with staff indicated that the resident was reaching for personal items that were at the bed side and subsequently fell from the bed. At the time of the fall the resident had two half bed rails in use at the head of bed. As a result of the fall the resident sustained an injury.

Residents #003, #004, #005, #006, #007, #008, #009 and #010 were observed during the inspection to have bed rails in use. The following is a summary of the health care record review, observations and staff interviews related to the use of bed rails for the identified residents:

Resident #003 – Was observed with two half rails in use at the head of bed. On the day of admission the use of bed rails were included in the plan of care. PSW #103 reported that resident #003 may hold on to the rails during transfers to and from the bed. The plan of care indicated that the resident was at fall risk with interventions including two bed rails at the head of bed. The resident had varied needs for bed mobility and extensive assist for transfers.

Resident #004 – Was observed with two half rails in use at the head of bed. When interviewed the resident indicated that the rails have been on the bed as long as the resident has resided in the room. The resident reported that the rails are not used for any purpose. PSW #107 reported that resident #004 rarely uses the rails and is independent for transfers and bed mobility. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; may use the grab rails for assistance with turning and repositioning.

Resident #005 – Was observed with two half rails in use at the head of bed. When interviewed the resident indicated that at times the resident will sometimes hold the rails when getting out of bed. PSW #107 reported that resident #005 does not use the rails for any purpose. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; was independent for bed mobility and transfers.

Resident #006 – Was observed with three half rails in use, two at the head of bed and one near the foot of the bed. When interviewed the resident indicated that the rails are to keep the resident from falling out of the bed. PSW #107 reported that resident #006 does not use the rails for any clinical purpose but rather the resident prefers to have them in use. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the HOB; limited assistance with bed mobility and transfers.

Resident #007 – Was observed with three half rails in use, two at the head of bed and one near the foot of the bed. PSW #112 reported that resident #007 will use the rails for bed mobility. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; extensive assistance with bed mobility.

Resident #008 – Was observed with two half rails in use at the head of bed. PSW #112 reported that resident #008 does not use the bed rails. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; was independent for bed mobility and transfers.

Resident #009 – Was observed with two half rails in use at the head of bed. PSW #112 reported that resident #009 may use the rails for bed mobility or to reposition. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; varied assistance needed for bed mobility and transfers.

Resident #010 - Was observed with two half rails in use at the head of bed. PSW #112 reported that resident #010 may use the rails during transfers. The plan of care indicated the resident was at fall risk with interventions including two bed rails at the head of bed; was extensive to total assistance for bed mobility and transfers.

The Director of Therapeutic Services was identified as the lead for the bed rail program in the home. During an interview with the Director of Support Services and the Director of Therapeutic Services on September 11, 2019, it was identified that all bed systems in the home are manufactured by Styker and that all beds have bed rails in use.

In review of the health care records for the identified eight residents, no resident assessment or risk benefit assessment had been completed with regards to the use

of bed rails and risk of entrapment. It was reported by the Director of Therapeutic Services that the home is working towards implementing a policy related to resident assessment of bed rails, but that it is not in place at this time. The Director of Therapeutic Services reported that in the interim, resident are referred to the Occupational Therapist (OT) when nursing staff identify the need. In the matter of the identified residents, no assessment by OT had been completed as it relates to the use of bed rails or entrapment risk.

Observations of the bed rails in use for the eight identified residents, determined the use of a curved rail, potentially impacting the entrapment risk at Zone 4. The most recent bed evaluations completed by the Director of Therapeutic Services and the Director of Support Services, indicated that Zone 4 passed in February 2018 and June 2019. On September 11, 2019, a demonstration of testing was conducted by the Director of Therapeutic Services and the Director of Support Services. The Director of Support Services assembled the cone and cylinder tool and conducted the initial tests. Initial tests were done prior to the mattress being pushed away from the rail being tested and the cone not at the edge of the mattress, this resulted in a fail of Zone 4. After discussion, the Inspector indicated the need to push the mattress away from the rail and it was identified that the cone was to be at the edge of the mattress. After making adjustments to the position of the mattress and cone, subsequent tests provided for a failure of Zone 4 as the rail touched at the line or just over the line into the red area of the cylinder.

In this way, the licensee failed to ensure that where bed rails are used, the resident was assessed and his or her bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

The severity of this issue was determined to be a level 3 as there was actual risk of harm to resident #003. The scope of the issue was a level 3, as all residents included in the inspection were identified with non-compliance. The compliance history is a level 2 as the home has previous non-compliance but not to section 15 of the LTCHA, 2007. (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 31, 2020(A2)

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 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 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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

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 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 19th day of June, 2020 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by EMILY BROOKS (732) - (A2)

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