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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
Telephone: (613) 569-5602
Facsimile: (613) 569-9670

Bureau régional de services d'Ottawa
347 rue Preston bureau 420
OTTAWA ON K1S 3J4
Téléphone: (613) 569-5602
Télécopieur: (613) 569-9670

Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
May 5, 2017	2017_617148_0014	021960-16, 025133-16, 025316-16, 025317-16, 034166-16, 000151-17, 000612-17, 004952-17, 005909-17, 006031-17, 006853-17	Critical Incident System

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

AMANDA NIXON (148)

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): April 3-7 and 10, 2017

This inspection included 11 critical incident reports, including five related to alleged resident abuse and six related to an injury to a resident for which the resident is sent to hospital and which results in significant change in health status.

During the course of the inspection, the inspector(s) spoke with the home's President and Chief Executive Officer (CEO), Vice President (VP) of Nursing, Assistant Vice President of Nursing, Restorative Lead Hand, Physiotherapist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), family members and residents.

The Inspector reviewed resident health care records, including physician orders, plans of care, documentation of care within Point of Care and the home's investigation notes, as applicable. In addition, the inspector observed resident's, the provision of care and services to residents, staff to resident interactions, resident to resident interactions and the resident's environment.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Hospitalization and Change in Condition
Minimizing of Restraining
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home

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

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that where bed rails were used, residents were assessed and his or her bed system evaluated in accordance with prevailing practices, to minimize risk to the resident.

On August 21, 2012, a notice was issued to Long-Term Care Home Administrators from the Ministry of Health and Long-Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (referred to as Health Canada Guidance Document). In the notice, it is written that this Health Canada Guidance Document is expected to be used as a best practice document.

The Health Canada Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the Health Canada 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 (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment for residents where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed

rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including, but not limited to, the resident's right to participate in the care planning process, the resident's medical needs, sleep habits and sleep environment, resident comfort in bed, and potential safety risks posed by using any type of bed rail. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident health care record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Further, the document, "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" is expected to be used as best practice to prevent resident entrapment when bed rails are used.

On April 5, 2017, Inspector #148 observed the room of resident #005 for the purposes of a critical incident inspection related to an injury for which the resident was sent to hospital. The critical incident report described the resident with dementia and a history of falls. On a specified date the resident develop swelling and pain to two extremities. In hospital, the injuries were diagnosed as pathological related to the resident’s diagnosis. During an observation of the residents bedroom, the Inspector noted that the resident’s bed system was equipped with quarter rails on either side of the bed, located at the head of bed. In addition, the mattress was wedged shaped on the sides, at both the head of bed near the rails and at the foot of the bed (later identified as a mattress with side bolsters). The mattress appeared to fit the bed frame, however, a gap was noted to be created between the mattress and rail due to the wedge shape; in addition, although no immediate disrepair was identified the rails had movement when pushed and pulled away from the mattress. The Inspector expanded the sample of residents to include resident #014 and #015, who were identified to have the same mattress and bed rails applied.

In discussion with the VP of Nursing, it was reported to the Inspector that the home has 288 bed systems. She reported that the management team recently established that of the 288 bed systems, 225 have bed rails in use. It was described that the home uses various mattresses, including those with side bolsters and therapeutic surfaces. Of the 15 bed systems with therapeutic mattresses, it was unknown which had bed rails in use. At this time the home has no formal tracking system established to communicate changes related to the bed system.

Inspector #148 discussed the bed systems for resident #005, #014 and #015 with the home's management team. It was reported to the Inspector that the home does not have a process in place to evaluate bed systems used in the home nor is there a process in place to conduct resident assessments; including when a new resident is admitted to the home or when a component of the resident's bed system was modified.

In discussion with the VP of Nursing and later the home's CEO, it was reported that the home is working to establish a process for resident assessment and bed evaluation and has recently purchased a bed evaluation tool. The senior management acknowledged their awareness of the Health Canada Guidance Document and intend to use this prevailing practice to guide their program development.

The scope of the non-compliance described above is "widespread" as residents using bed rails are not assessed nor are the bed systems evaluated. The non-compliance presents a "potential for actual harm" given the failure to assess residents related to the risk of bed rail use and conduct bed system evaluations, as per prevailing practices described in the FDA 2003 clinical guidance document. As a result of these factors, a compliance order will be issued.

Additional Required Actions:

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

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. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident.

On a specified date, the home submitted a critical incident report describing the un-witnessed fall of resident #009 which resulted in an injury; the resident was noted to have a history of falls.

In separate interviews, Inspector #148 spoke with PSW #120 and PSW # 122 , who are both familiar with the resident's care. PSW #122 indicated that the resident can become aggressive when care is provided. Both PSWs indicated that the resident requires one person for transfer as the resident will become agitated when two staff approach; they noted that a second staff person is near by if assistance is needed. Both reported that the resident does best with verbal cuing rather than physical assist for transfers. As it relates to toileting PSW #120 and PSW #122 noted that the resident is usually walked to the bathroom by two staff members, the resident will then sit with verbal cues. PSW #122 noted that toileting is not a regular occurrence as the resident is resistive to it and usually the resident is incontinent. Both PSWs noted that the resident's incontinent product is changed when the resident gets up from bed in the morning and then at approximately 1300 hours, the resident is provided with a change and toileted, although rarely does the resident void. PSW #120 and RPN #118, reported that the resident no longer uses a catheter.

A review of the Point of Care documentation maintained by the PSWs, indicate that the resident is provided with two person extensive assistance with toileting and one to two person extensive to total assist with transfers.

The plan of care for resident #009 indicated that the resident requires limited, one person assist with toileting, will be toileted after meals and uses a foley catheter. The plan of care further describes that the resident requires two staff to assist with transfers.

The most recent RAI-MDS assessment indicates that the resident requires one person for toileting, that the resident is fully incontinent of bowel and bladder with use of briefs and is not on a toileting schedule. In addition, the assessment denotes the resident requires the extensive physical assist of two staff for transfers. The MDS assessment describes the resident is at risk for falls, requiring staff assistance for activities of daily living and exhibits agitated and aggressive behaviours during care.

The plan of care, as it relates to toileting and transfers for resident #009, does not set out the care based on the resident's needs and preferences.
(Log 025317-16) [s. 6. (2)]

2. On a specified date, the home submitted a critical incident report describing the un-witnessed fall of resident #012 which resulted in injury; resident #012 was described as a high risk for falls.

Resident #012 was observed by the Inspector to be seated in a wheelchair with seat belt applied, on two separate occasions. When the resident was questioned the resident was able to release the belt. On April 7, 2017, the resident was observed to release the belt and attempt to stand. PSW #123 approached the resident, used distraction techniques and the resident was placed back into the chair and the seat belt reapplied. When questioned by the Inspector, PSW #123, who was responsible for the resident's care, indicated that the resident is not safe to stand on his/her own and the seat belt is to remind the resident to stay seated. During interviews with the Inspector, PSW #123 and PSW #124 indicated that resident #012 requires two person pivot assist with transfers due to the resident being unsteady on his/her feet.

The health care record for resident #012 was reviewed. The plan of care indicates that the resident requires one person transfer and use of a tilt wheelchair with no seat belt for posture, positioning and pressure management.

The plan of care for resident #012, as it relates to transfers and use of seat belt, does not set out the care based on the resident's needs and preferences.
(Log 000151-170 [s. 6. (2)]

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (1) A resident may be restrained by a physical device as described in paragraph 3 of subsection 30 (1) if the restraining of the resident is included in the resident's plan of care. 2007, c. 8, s. 31. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident may be restrained by a physical device if the restraining of the resident is included in the resident's plan of care.

Resident #005 was observed by the Inspector on April 5, 2017, to be seated in a wheelchair with tilt and front closure lap belt applied. Inspector #148 approached the resident while seated in the wheelchair on April 5, 2017. The Inspector engaged the resident with questions about the lap belt while the inspector point to and/or touched the belt. It was determined that the resident could not release the lap belt.

RPN #109 who indicated he was new to the unit, reported he was not sure if the belt was a restraint, noting that the resident can release the lap belt. The Inspector spoke with PSW #108, who was identified as float on the floor but who had provided morning care to the resident. The PSW indicated that she had applied the belt noting that if the belt is on the chair and not tied to the back she assumes that it needs to be applied. PSW #108 was not sure why the lap belt was required for this resident.

The Inspector spoke with PSW #111, who is a regular day shift PSW for this unit. PSW #111 indicated that the resident usually wears the belt during the day and the tilt of the chair is usually applied between meals. The PSW indicated that it was unlikely that the resident would be able to release the belt. She further indicated that the belt may be applied as the resident will reach and try to get out of the chair and is at risk for falls; PSW #111 noted that with the tilt applied it is unlikely that the resident would need the lap belt.

The resident's plan of care was reviewed and indicated that the resident requires a tilt wheelchair for posture, positioning and pressure management. In review of the health care record, including the plan of care and physician orders, there was no indication for use of a lap belt.

The use of a lap belt as a restraint for resident #005 was not included in the resident's plan of care.
(Log 021960-16) [s. 31. (1)]

Issued on this 5th day of May, 2017

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2017_617148_0014
Log No. / Registre no:	021960-16, 025133-16, 025316-16, 025317-16, 034166-16, 000151-17, 000612-17, 004952-17, 005909-17, 006031-17, 006853-17
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 5, 2017
Licensee / Titulaire de permis :	ST. PATRICK'S HOME OF OTTAWA INC. 2865 Riverside Dr., OTTAWA, ON, K1V-8N5
LTC Home / Foyer de SLD :	ST PATRICK'S HOME 2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Morris

To ST. PATRICK'S HOME OF OTTAWA INC., 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

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

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 is ordered to:

1. Evaluate all bed systems where bed rails are used in the home, in accordance with the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003). Establish and implement a process for ensuring that any bed system failures are addressed immediately by taking the necessary corrective actions. All evaluations and actions taken to address bed system failures are to be documented.

2. Develop and implement a documented multidisciplinary team assessment process for all residents with one or more bed rails in use (including partial rails), and for all residents for which the use of one or more bed rails are being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003). As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

3. Ensure the interdisciplinary team assessment process identifies potential clinical and environmental interventions which may serve as an alternative to bed rail use. Documentation of the risk-benefit assessment must be apparent in the resident's health care record.

4. Update the resident's written plan of care to reflect the interdisciplinary team assessment. Include all required information as specified in the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003).

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, residents were assessed and his or her bed system evaluated in accordance with prevailing practices, to minimize risk to the resident.

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resident was sent to hospital. The critical incident report described the resident with dementia and a history of falls. On a specified date the resident develop swelling and pain to two extremities. In hospital, the injuries were diagnosed as pathological related to the resident's diagnosis. During an observation of the residents bedroom, the Inspector noted that the resident's bed system was equipped with quarter rails on either side of the bed, located at the head of bed. In addition, the mattress was wedged shaped on the sides, at both the head of bed near the rails and at the foot of the bed (later identified as a mattress with side bolsters). The mattress appeared to fit the bed frame, however, a gap was noted to be created between the mattress and rail due to the wedge shape; in addition, although no immediate disrepair was identified the rails had movement when pushed and pulled away from the mattress. The Inspector expanded the sample of residents to include resident #014 and #015, who were identified to have the same mattress and bed rails applied.

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In discussion with the VP of Nursing and later the home's CEO, it was reported that the home is working to establish a process for resident assessment and bed evaluation and has recently purchased a bed evaluation tool. The senior management acknowledged their awareness of the Health Canada Guidance Document and intend to use this prevailing practice to guide their program development.

The scope of the non-compliance described above is "widespread" as residents

using bed rails are not assessed nor are the bed systems evaluated. The non-compliance presents a "potential for actual harm" given the failure to assess residents related to the risk of bed rail use and conduct bed system evaluations, as per prevailing practices described in the FDA 2003 clinical guidance document. As a result of these factors, a compliance order will be issued. (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 04, 2017

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 5th day of May, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : AMANDA NIXON

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