Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 27, 2019	2019_633577_0011	003877-19, 008339-19	Critical Incident System

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

DEBBIE WARPULA (577), KATHERINE BARCA (625), LAUREN TENHUNEN (196)

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 23-26, 29, 30 and May 1-3, 6-9, 2019.

The following intakes were inspected upon during this Critical Incident System (CIS) inspection:
- One intake related to improper care; and

-One intake related to bedrails and entrapment.

A Complaint inspection #2019_633577_0010 and a Follow Up inspection #2019_633577_0012 were conducted concurrently with this CIS inspection.

Non compliance related to LTCHA 2007, c.8, s. 24 (1), r. 71 (3) a, s. 23 (1) a, s. 20 (1) identified during this CIS inspection will be identified in Complaint inspection #2019_633577_0010.

During the course of the inspection, the inspector(s) spoke with the Regional Director for Extendicare, Administrator, Director of Care (DOC), Clinical Managers, Maintenance Manager, Maintenance Worker, Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs).

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, reviewed the home's internal investigation notes, bed safety documents and reviewed licensee policies and procedures.

The following Inspection Protocols were used during this inspection:
Minimizing of Restraining
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

1 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails 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.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, which described a bed entrapment incident. The report indicated that resident #001 was entrapped in their bed system and were experiencing a significant change in health status which required hospitalization. The report also identified that the bed safety analysis for this resident's CS 7 bed system had not been completed.

The Director provided the following guidance memorandum to the sector, on March 27, 2019, that read:

"MOHLTC sent a memo to licensees in 2012 advising them to use the Health Canada Guideline (HCG) "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" as a guiding best practice document to deal with the risk of bed entrapment and the evaluation of bed systems. Listed below are two very important companion guides referenced throughout the HCG. They outlined prevailing practices related to assessing residents and to modifying bed systems—inspectors use these two guides, along with the HCG to determine overall compliance with s. 15(1) of O. Reg 79/10.

- Clinical Guidance for the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings, April 2003; and
- A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment June 21, 2006.

Prior to this memo, on August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was expected to be used as the best practice document in LTC Homes and provided clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006". The guide included information with respect to various options and corrective strategies available to mitigate entrapment zones; a guide to buying beds; how to inventory bed systems, and reviewed the dimensional criteria of bed systems. The documents were considered prevailing practices, which were predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

A review of the home's policy, "Bed Safety - Prevention of Entrapment - LTC 5-80", revised June 2016, identified the following:
- each resident and their bed must have been assessed individually for entrapment risks; interventions intended to reduce the risk of entrapment must be tailored to meet each individual's needs;
- all residents should have had an individualized "Bed Safety Analysis" completed;
- a "Bed Rail Safety Analysis" was to be completed on admission and whenever a "Bed Safety Analysis" was performed; whenever a resident changed his/her mattress, bed fame, or any other bed-related products; and whenever a staff member felt it was necessary for resident safety; and
- Maintenance staff would perform quarterly bed safety audits to have ensured bed rails and all other parts of the bed were free from defect and were working properly.

A review of resident #001's health care records was conducted by Inspector #196. The physician's order on a identified date, read, "Transfer to TBRHSC for further assessment", and a progress note adjacent to the order read that the resident was found

in a compromised position. A "Bed Safety Analysis" document for resident #001 on a specified date, for a FL -14 bed system was completed and in the resident's chart.

A review of the home's investigation file related to this incident was conducted. The notes recorded by Clinical Manager #100, during an interview with PSW #101, indicated that "it appeared that the intervention on their bed wasn't fully up – locked in place".

During an interview with Clinical Manager #100, they reported that resident #001 had a "Bed Safety Analysis" completed on an identified date, for a FL-14 bed system. They further reported that at the time of the bed safety incident the resident was in a CS 7 bed system.

During an interview with Maintenance Manager #102, they reported that resident #001's bed had been changed from a FL-14 to a CS 7 bed system on an identified date. They added that bed assessments had been done for the two types of bed systems used in the home, CS 7 and FL-14, with quarter and full bed rails and Geo Matt 80 inch mattresses; and the Occupational Therapist (OT) had provided recommendations based upon a sample bed. They further confirmed this was not individualized for each resident in the home. In addition, Maintenance Manager #102 confirmed that the quarterly bed audits as referenced in the home's policy, had not been completed.

During an interview with the Administrator, they reported that resident #001 had a zone three entrapment incident. They confirmed that the resident had not had an individualized "Bed Safety Analysis" or a "Bed Rail Safety Analysis" completed, according to the home's policy, when the resident was moved into a CS 7 bed system on November 22, 2018. [s. 15. (1) (a)]

2. During the inspection, both Inspector #196 and Maintenance Manager #102 conducted a random survey of bed systems in use for residents with bed rails that were elevated and engaged. The following was observed and identified:

-resident #025 – CS 7 bed system, 80 inch Geo Matt with bilateral upper quarter bed rails elevated and engaged;
-resident #026 – CS 7 bed system with 80 inch Geo Matt with bilateral upper quarter bed rails elevated and engaged;
-resident #003 – CS 7 bed system with 80 inch Geo Matt with bilateral upper quarter bed rails elevated and engaged;
-resident #027 – CS 7 bed system with 80 inch Geo Matt with bilateral upper quarter bed

rails elevated and engaged;
-resident #028 – FL-14 bed system with with 80 inch Geo Matt with bilateral upper quarter bed rails elevated and engaged; and
-resident #029 – FL-14 bed system with 80 inch Geo Matt with bilateral upper quarter bed rails elevated and engaged.

Inspector #196 conducted a record review of resident's #025, #026, #003, #027, #028, and #029 to determine whether a "Bed Safety Analysis" or a "Bed Rail Safety Analysis" had been completed according to the licensee's policy. The inspector found that there were no assessments for a "Bed Safety Analysis" or a "Bed Rail Safety Analysis", documented on their charts.

A review of the licensee's policy, "Bed Safety - Prevention of Entrapment - LTC 5-80", revised June 2016, identified the following:

- each resident and his/her bed must have been assessed individually for entrapment risks, and interventions intended to reduce the risk of entrapment must be tailored to meet each individual's needs;
- all residents should have had an individualized "Bed Safety Analysis" completed; and
- a "Bed Rail Safety Analysis", was to be completed on admission; whenever a "Bed Safety Analysis" was performed; whenever a resident changed his/her mattress, bed fame, or any other bed-related products; and whenever a staff member felt it was necessary for resident safety.

During an interview with DOC #104, they reported that if the document "Bed Safety Analysis" was not completed and in the resident's chart, then it was not done for the resident. They further clarified that the "Bed Safety Analysis" was on one side of the document and the "Bed Rail Safety Analysis" was on the other side. [s. 15. (1) (a)]

3. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

A Critical Incident System (CIS) report was submitted to the Director on an identifed date, which described a bed entrapment incident. The report identified that the bed safety analysis for this resident's CS 7 bed system had not been completed. See WN #1, finding #1, for further details.

A review of the homes policy, "Bed Safety - Prevention of Entrapment - LTC 5-80",

revised June 2016, identified the following:

- each resident and his/her bed must have been assessed individually for entrapment risks, and interventions intended to reduce the risk of entrapment must be tailored to meet each individual's needs.

During an interview with RPN #105, they indicated that they were unaware of any bed safety analysis and assessments of resident's beds and bed rails, except for those resident's that had full bed rails on their beds.

During an interview with RPN #106 they reported that they could not recall doing any bed or bed rail assessments on residents.

During an interview with RPN #107 they reported that they could not recall any documents that were to be completed for bed assessments or for bed rail use.

During an interview with Clinical Manager #108, when asked about the requirement to do bed safety assessments they reported that all residents were supposed to have had a bed safety analysis done and placed on their chart.

During an interview with Clinical Manager #100, they reported that resident #001 had a "Bed Safety Analysis" completed on an identified date, for a FL-14 bed system. They further reported that at the time of the bed safety incident the resident was in a CS 7 bed system.

During an interview with Maintenance Manager #102, they reported that bed entrapment zones had not been assessed on resident #001's bed. They provided a document titled, 'Intervention Suggestions to Enhance Bed Safety', (for beds in use at HRM), which identified that the CS 7 bed system with the split rails in place and the Geo Matt 80 inch had been tested for safety, and when this bed frame and mattress were in good condition, there should not be any issues with entrapment. They added that the Occupational Therapist (OT) had provided recommendations based upon a sample bed. They further confirmed this was not individualized for each resident in the home.

During an interview with the Administrator, they reported that resident #001 had a zone three entrapment incident. They confirmed that the resident had not had an individualized "Bed Safety Analysis" or a "Bed Rail Safety Analysis" completed according to the home's policy, when the resident was moved into a CS 7 bed system on an identified date.

During an interview with the Extendicare Regional Director #109, they reported that the home would be incorporating the Extendicare policy on bed safety; that education had started and a "blitz" was to occur with a new tool and a team had been assembled. They added that a spread sheet would be implemented to identify the beds and serial numbers, and mattresses. [s. 15. (1) (b)]

4. Inspector #196 reviewed bed safety and bed assessment information, specific to the CS 7 and FL-14 bed systems used in the home. In addition, a list of 18 residents from an identified home area that used the FL-14 bed system with 80 inch Geo Mattresses was reviewed.

Observations of a specific unit were conducted by the Inspector, and the following was noted:
- 18 FL-14 bed systems were identified in resident rooms;
- 15 of these beds had bilateral upper quarter bed rails elevated and engaged; and
- three of the beds did not have bed rails elevated or engaged.

The health care records for a sample of seven of the 18 residents utilizing the15 FL-14 bed systems was reviewed and there were no "Bed Safety Analysis" documents on their charts, for any of the bed systems within the sample.

During an interview with Maintenance Manager #102, they reported that there were 18, FL-14 bed systems with the standard 80 inch Geo Mattress in use for residents on the Spruce Grove unit. Together with Inspector #196, the zones of entrapment diagram in the licensee's policy, "Bed Safety - Prevention of Entrapment - LTC 5-80", revised June 2016, was reviewed. In addition, a document dated January 10, 2017, FL-14 - 80 inch Geo Max Mattress, indicated that zone four had failed, and read, "The Geo Max Mattress has two primary fail locations that result from the function of the frame and mattress together. These include zone 4 and zone 7 (at foot board)". When questioned what had been done to mitigate the bed entrapment risk for those residents currently utilizing the FL-14 beds with 80 inch Geo Mattress, as zone four was identified as a fail zone, Maintenance Manager #102 reported that the lower bed rails had been tied down. When informed of the same zone four with the upper bed rails by the Inspector, Maintenance Manager #102 was unable to specify what had been done to mitigate resident risk and this zone of entrapment for those residents currently using this bed system.

During an interview with Extendicare Regional Director #109, they confirmed with

Inspector #196 that they had been made aware that some residents had not had a bed safety analysis conducted. [s. 15. (1) (b)]

Additional Required Actions:

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

Issued on this 31st day of May, 2019

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

Original report signed by the inspector.

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

Ministère 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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	DEBBIE WARPULA (577), KATHERINE BARCA (625), LAUREN TENHUNEN (196)
Inspection No. / No de l'inspection :	2019_633577_0011
Log No. / No de registre :	003877-19, 008339-19
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	May 27, 2019
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sheila Clark

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

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

a) Re-evaluate all bed systems in the home using the weighted cone and cylinder tool in accordance with "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. Specifically, the bed systems are to be evaluated for zones 2, 3, and 4, and for beds with rotating assist rails, the bed rails are to be evaluated in both the transfer (vertical position) and in the guard (horizontal) position.

b) Where one or more bed rails will be applied or attached to a bed frame, equip the bed frame with mattress keepers that will keep the mattress from sliding side to side, and will allow the mattress to fit properly between the keepers (mattresses must not sit on top of the keepers).

c) Where bed rails do not pass zone 2, 3, or 4, mitigate the bed system in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" or equip the bed systems with a different manufacturer's compatible bed mattress or bed rail that passes zones 1 to 4.

d) Inspect each bed when conducting bed system evaluations for condition as

per the manufacturer's recommendations (castor brakes, remote, manual cranks, head and foot board condition, mattress condition, bed rail condition).

e) Educate all bed system evaluators on the requirements of the Health Canada guidelines entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, March 2008" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006).

f) Make available the results of the bed system re-evaluation to the interdisciplinary team who participates in assessing each resident for bed rail safety.

g) Keep accurate and detailed records as to the zones that were tested, what has been done to a bed once it is initially evaluated (i.e. what specific change was made to the bed, the date the change was made, bed and mattress identifier, who made the changes, the re-evaluation date, auditor name and results).

h) Amend or update policy LT5-80 entitled "BED SAFETY-PREVENTION OF ENTRAPMENT" to include a "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006) and any additional information and guidance for bed system evaluators for a thorough evaluation.

i) Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

1. The licensee has failed to ensure that 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.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, which described a bed entrapment incident. The report indicated that resident #001 was entrapped in their bed system and were experiencing a significant change in health status which required hospitalization. The report also

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2. During the inspection, both Inspector #196 and Maintenance Manager #102 conducted a random survey of bed systems in use for residents with bed rails that were elevated and engaged. The following was observed and identified:

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During an interview with the Administrator, they reported that resident #001 had a zone three entrapment incident. They confirmed that the resident had not had an individualized "Bed Safety Analysis" or a "Bed Rail Safety Analysis" completed according to the home's policy, when the resident was moved into a CS 7 bed system on an identified date.

During an interview with the Extendicare Regional Director #109, they reported that the home would be incorporating the Extendicare policy on bed safety; that education had started and a "blitz" was to occur with a new tool and a team had been assembled. They added that a spread sheet would be implemented to identify the beds and serial numbers, and mattresses. [s. 15. (1) (b)] (196)

4. Inspector #196 reviewed bed safety and bed assessment information, specific to the CS 7 and FL-14 bed systems used in the home. In addition, a list of 18 residents from an identified home area that used the FL-14 bed system with 80 inch Geo Mattresses was reviewed.

Observations of a specific unit were conducted by the Inspector, and the following was noted:
- 18 FL-14 bed systems were identified in resident rooms;
- 15 of these beds had bilateral upper quarter bed rails elevated and engaged; and
- three of the beds did not have bed rails elevated or engaged.

The health care records for a sample of seven of the 18 residents utilizing the15 FL-14 bed systems was reviewed and there were no "Bed Safety Analysis" documents on their charts, for any of the bed systems within the sample.

During an interview with Maintenance Manager #102, they reported that there were 18, FL-14 bed systems with the standard 80 inch Geo Mattress in use for residents on the Spruce Grove unit. Together with Inspector #196, the zones of entrapment diagram in the licensee's policy, "Bed Safety - Prevention of Entrapment - LTC 5-80", revised June 2016, was reviewed. In addition, a document dated January 10, 2017, FL-14 - 80 inch Geo Max Mattress, indicated that zone four had failed, and read, "The Geo Max Mattress has two primary fail locations that result from the function of the frame and mattress together. These include zone 4 and zone 7 (at foot board)". When questioned what had been done to mitigate the bed entrapment risk for those residents currently utilizing the FL-14 beds with 80 inch Geo Mattress, as zone four was identified as a fail zone, Maintenance Manager #102 reported that the lower bed rails had been tied down. When informed of the same zone four with the upper bed rails by the Inspector, Maintenance Manager #102 was unable to specify what had been done to mitigate resident risk and this zone of entrapment for those residents currently using this bed system.

During an interview with Extendicare Regional Director #109, they confirmed with Inspector #196 that they had been made aware that some residents had not had a bed safety analysis conducted. [s. 15. (1) (b)]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was actual harm. In addition, the home's compliance history which indicated a Voluntary Plan of Correction (VPC) was issued during a Resident Quality (RQI) Inspection #2016_435621_0012, on October 11, 2016.
(196)
(196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2019

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 27th day of May, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Debbie Warpula

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