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

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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
Mar 14, 2022	2021_857129_0011	018849-21, 019426-21	Critical Incident System

Licensee/Titulaire de permis

955464 Ontario Limited
3700 Billings Court Burlington ON L7N 3N6

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

Crescent Park Lodge
4 Hagey Avenue Fort Erie ON L2A 5M5

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

PHYLLIS HILTZ-BONTJE (129)

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): December 7, 8, 9, 10, 13, 14, 15, 17, 20, 21, 22, 2021, January 6, 7, 10, 11, 12, 2022.

The following intakes were inspected:
018849-21 and 019426-21 related to falls

During the course of the inspection, the inspector(s) spoke with residents, Personal Support Workers (PSW), Registered Practical Nurses (RPN), Registered Nurses (RN), RAI-MDS Coordinator, Physiotherapist, Director of Care, and the Administrator.

During the inspection resident care was observed, resident clinical records were reviewed, resident bed systems were reviewed, a bed safety survey was reviewed, Critical Incident Reports (CIR) submitted by the home were reviewed, licensee policies related to the use of bed rail, safe resident handling and falls were reviewed and IPAC Checklist A1 was completed.

This inspection was conducted concurrently with Complaint Inspection #2021_857129_0010 related to infection prevention and control.

PLEASE NOTE: Findings of non-compliance related to Ontario Regulation 79/10 section 8 (1) (b) related to compliance with the licensee's policies were identified during this inspection and have been issued in Inspection report #2021_857129_0010.

The following Inspection Protocols were used during this inspection:
Falls Prevention

During the course of this inspection, Non-Compliances were issued.
- **6 WN(s)**
- **1 VPC(s)**
- **3 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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that four residents were provided with care in accordance with the directions in their plans of care.

a) The licensee failed to ensure that care set out in a resident's plan of care related to assistance during transfers was provided to the resident as set out in the plan of care.

The resident had been identified at risk for falling. Following assessments of the resident, their care plan was developed and directed that the resident required the assistance of staff for transfers and the use of a mechanical lift.

Two Personal Support Workers (PSWs) confirmed they assisted the resident to stand, the resident was unable to continue to stand and fell, which resulted in the resident receiving an injury.

The Physiotherapist confirmed that due to the resident's unreliable ability to stand and bear their own weight, only Physiotherapist Assistants were authorized to stand the resident.

The Resident Assessment Instrument (RAI) Coordinator confirmed the resident’s care plan did not include directions that PSWs were to assist the resident to stand during transfers.

During an interview one PSW confirmed that they had not reviewed the care plan or Kardex prior to providing care to the resident, and they were not aware of the directions in the care plan related the type of assistance the resident required to transfer.

The care specified in the resident's care plan related to assistance to transfer was not provided to the resident at the time of this incident.

The failure of staff to ensure the resident received the care that had been specified in the care plan related to assistance to transfer resulted in the resident sustaining an injury when they fell.

Sources: the resident's electronic care plan, written statements by to PSWs, a Critical Incident Report and interviews with a PSW, the Physiotherapist and the RAI Coordinator.

b) The licensee has failed to ensure that care specified in a second resident's plan of care related to falls prevention was provided as specified in the plan, specifically, the use of a chair alarm and ensuring the call bell was accessible to the resident.

The resident had been identified at risk for falling and care plan interventions to manage the risk included ensuring the call bell was accessible to the resident and a chair alarm was to be used to remind the resident to wait for assistance of staff before leaving their chair.

During the inspection it was observed that the resident was sitting in their room and the call bell was not accessible to them. At this time the resident attempted to reach the call bell that was lying on a chair that had been positioned behind the resident and they acknowledged that they were not able to reach the call bell.

At this time, it was also observed that a chair alarm did not appear to be in use.

A PSW was asked to attend to the resident, and they confirmed that a chair alarm had not been put in place.

The failure of staff to ensure that care plan interventions identified in the resident's plan of care were in place related to the call bell and a chair alarm, increased the risk that the resident would attempt to leave their chair and fall.

Sources: the resident's electronic care plan, observations of the resident and interviews with the resident and a PSW.

c) The licensee has failed to ensure that care specified in a third resident's plan of care related to falls prevention was provided as specified in the plan, specifically, that the call bell was placed within reach of the resident.

The resident had been identified at risk for falling and care plan interventions to manage the risk included ensuring the call bell was accessible to the resident.

At the time of this inspection, it was observed that the resident was in bed and a family member was in the room. It was observed that the resident's call bell cord had been wrapped around the underside of the bed frame and the resident would not have been able to access the call bell to call for assistance. Both the family member and a PSW,

who were in the room at the time, confirmed that the resident would not have been able to reach the call bell to call for assistance.

The resident's care plan indicated the call bell was to be accessible to the resident as a fall prevention strategy and that the resident was able to call for assistance using the call bell.

The failure of staff to ensure that care plan interventions identified in the resident's plan of care were in place related to the accessibility of the call bell, increased the risk that the resident would attempt to self-ambulate and fall.

Sources: Observations of the resident in their room, the resident's electronic care plan and interviews with the family member and a PSW.

d) The licensee failed to ensure care specified in a fourth resident's plan of care related to falls prevention was provided as specified in the plan, specifically, that the call bell was placed within reach of the resident.

The resident had been identified at risk for falling and care plan interventions to manage the risk included, ensuring the call bell was accessible to the resident.

At the time of this inspection, it was observed that the resident was sitting in their room and did not have access to the call bell. A PSW who was in the room at the time of the observation acknowledged that the resident did not have access to the call bell.

The failure of staff to ensure that care plan interventions identified in the resident's plan of care were in place related to the accessibility of the call bell, increased the risk that the resident would attempt to self-ambulate and fall.

Sources: Observations of the resident, the resident's electronic care plan and an interview with a PSW.

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 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 when bed rails were used for four residents that the residents were assessed, and their bed systems were evaluated in accordance with prevailing practices.

The following documents had been provided to all long-term care home Administrators to be used as best practice documents in Long-Term Care homes: "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" developed by the Hospital Bed Safety Workgroup and "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" published by Health Canada.

The DOC confirmed the bed rail assessment used in the home was part of a safety assessment identified as "Safety Assessment-Fall Risk-Restraints, and Bed Rails-V2", which was completed electronically.

The bed rail use clinical assessment process used in the home was reviewed and it was determined that it was not developed fully in accordance with the prevailing practice documents.

The DOC explained that before, when the home used the Safety Assessment, they would use this tool to complete bed rail assessment and acknowledged that since they had changed to the Falls Risk Assessment Tool (FRAT) tool to assess the risk for falls

they had not been completing assessments of the resident prior to the application of bed rails.

a) On two dates a resident was observed to be in bed and appeared to be sleeping. On both occasions it was observed that the resident was in an unusual position with their head angled sharply towards a half-length bed rail that was in the up position on the right side of the bed. This safety concern was brought to the attention of staff who attended the resident.

The resident's plan of care indicated the use of bed rails were implemented on the day the resident was admitted, at the request of the resident and a family member. Directions to use half-length bed rails on both sides of the bed when the resident was in bed for bed mobility was added to the care plan. The plan of care also identified the following care requirements: staff assistance for bed mobility, was at risk for falling and assistance of staff with a mechanical lift for transfers was required.

A review of the assessment process confirmed it did not incorporate a process by which the resident's sleep patterns, habits and behaviours could be evaluated or observed while sleeping in bed with or without the application of bed rails, as identified in the prevailing practice guidance documents. The licensee's policy "Bed Rails-Safe Use And Entrapment Risk Management" dated November 2017, directed the Safety assessment was to be completed upon admission and did not direct staff to observe the resident for sleep patterns, habits, or behaviours before entering data on the Safety assessment.

The resident's safety assessment was completed on the day of admission and registered staff who completed the assessment documented the resident's sleep patterns and sleep preferences were unknown because the resident was a new admission and the assessment did not identify the conclusion reached, related to the use of bed rails, based on the assessment that was completed.

According to the assessment, both the resident and a family member requested the use of bed rails, they had signed the "Living at Risk" form and the request for bed rails was made following the provision of education to the resident and the family member. The assessment did not identify a conclusion based on information collected and the use of two half bed rails were implemented on the day the resident was admitted to the home. The licensee followed the request of the resident and the family member without balancing the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the legislation.

The assessment form did not include a section that could be completed by the assessor indicating what bed rail alternatives were trialed prior to applying the bed rails, as identified in the prevailing practice documents. According to the resident's plan of care, bed rails were used as a personal assistive device related to bed mobility, however, alternatives to the use of bed rails such as transfer pole, raised perimeter mattress or adjustable bolsters had not been considered.

The questions included on the assessment form did not include key questions related to medication use. Relevant questions were noted to include resident overall mobility, falls history bed rail use concerns such as attempts to transfer toilet self while lacking ability to safely do so and history of entrapment. However, when answered with a "yes" or a "no", the form did not provide direction to registered staff. The assessment form did not include a conclusion section for the assessor to identify if bed rails were recommended or not recommended and the reasons based on the outcome of the observation period and responses to questions. No conclusion related to the use of bed rails for the resident was documented.

There was no evidence to indicate that the resident had been assessed or their bed system evaluated prior to the use of bed rails.

The failure to complete a bed rail safety assessment and a bed system evaluation in accordance with prevailing practices increased the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: Observations of the resident and their bed system, the resident's care plan, "Safety Assessment-Fall Risk-Restraints, and Bed Rails-V2" document, “Safety Assessment, “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003",“Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008”,Joerns Bed Safety Audit, licensee's "Bed Rails-Safe Use And Entrapment Risk Management" policy and interview with DOC.

b) At the time of this inspection a second resident was noted to have two stationary assist bed rails in place a quarter the way down from the head of the bed on both sides of the bed.

The resident's plan of care indicated the use of bed rails were implemented.

There was no evidence in the clinical record or records provided by the home to confirm that the resident had been assessed and their bed system evaluated prior to the use of bed rails.

The resident was not assessed, and their bed system was not evaluated prior to bed rails being applied to their bed and their use included in the resident’s care plan.

The failure to complete a bed rail safety assessment and a bed system evaluation in accordance with prevailing practices increased the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: the resident's care plan, observation of the resident bed system and an interview with the DOC.

c) At the time of this inspection a third resident was noted to have two 1/4 length bed rails in place on both sides of the bed.

The resident’s care plan indicated the use of bed rails were implemented at the request of the resident’s family member and consent for acceptance of resident risk had been signed by the family member.

A "Safety Assessment-Fall Risk, Restraint and Bed Rail -V3" assessment document completed four months prior to the inspection indicated that bed rails were not in use.

There was no evidence in the clinical record or records provided by the home to confirm that the resident had been assessed and their bed system evaluated prior to the use of bed rails.

The resident was not assessed, and their bed system was not evaluated prior to the bed rails being applied to their bed and included in their care plan.

The failure to complete a bed rail safety assessment and a bed system evaluation in accordance with prevailing practices increased the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: the resident's care plan, observation of the resident and their bed system bed system and an interview with the DOC.

d) At the time of this inspection a fourth resident was noted to have two full length bed rails in place and in use by the resident.

The resident’s plan of care indicated bed rails were implemented.

A "Safety Assessment-Fall Risk, Restraint and Bed Rail -V3" assessment had not been completed for the resident.

There was no evidence in the clinical record or records provided by the home to confirm that a bed rail assessment and a bed system evaluation had been completed for the resident.

The resident was not assessed, and their bed system was not evaluated prior to bed rails being applied to their bed and included in their care plan.

The failure to complete a bed rail safety assessment and a bed system evaluation increased the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: the resident's care plan, observation of the resident and their bed system bed system and an interview with the DOC.

2. The licensee failed to take steps to prevent resident entrapment when they did not take immediate action when it was identified that several resident beds had failed entrapment zone testing.

An audit of bed safety conducted by a representative from a bed supply company on September 22, 2021, identified that eight beds had failed entrapment zone testing for zones six and seven.

The written audit record also contained handwritten entries made by a maintenance person that included check marks in the additional note section of the audit form for the eight identified beds and a handwritten entry on a blank portion of the document that indicated “Failed parts corrected December 6, 2021”.

The failure of staff to immediately correct and document the correction of beds that failed entrapment zone testing increased the risk of injury and possible entrapment for the

residents who may have been using the failed beds or residents who may be moved into those beds.

Sources: a Bed Safety Survey document and interview with the DOC.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring techniques when they assisted a resident who had fallen.

Staff did not use safe transferring techniques when they assisted a resident who had fallen.

The resident had experienced a medical event in the past that affected their mobility and the Physiotherapist had identified that the resident was not able to stand and required the use of a mechanical lift for transfers, which was identified in the resident's plan of care.

Two PSWs confirmed in written statements provided to the DOC, that the resident was unable to bear their weight when they assisted the resident to stand.

Both PSWs indicated that they attempted unsuccessfully to manually lift the resident into their chair and then lowered the resident to the floor. A third PSW was called to assist, and the resident was manually lifted by the staff from the floor into their chair without first being assessed for injuries by a registered nurse. The PSWs indicated that on both occasions they transferred the resident by looping their arm under each arm of the resident and manually lifted the resident.

The transfer technique used by the PSWs resulted in the total weight of the resident's body supported solely by the resident's shoulders during the attempted transfer into the chair as well as when they manually lifted the resident from the floor.

Clinical notes indicated that in the morning following the incident the resident complained of pain which required the administration of pain medication, and an x-ray report indicated the resident had sustained an injury.

During an interview with the resident, they confirmed they still had pain form their injury, sometimes it is worse than other times and they receive medications that sometimes help.

The DOC acknowledged that the care of the resident by the PSWs was not appropriated or safe, the PSWs had not followed the resident's care plan or directions contained in the licensees polices when they performed transfers of the resident.

The failure of staff to implement safe transfer techniques resulted in the resident experiencing pain from an injury that resulted in a significant change in their health status.

Sources: Interview with the resident, the resident's medical history and clinical progress notes, an x-ray report, written statements by two PSWs and interviews with the Physiotherapist and the DOC.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

The licensee failed to ensure staff complied with a condition of the license when they failed to implement the Resident Assessment Instrument Minimum Data Set (RAI-MDS) and complete a significant change assessment following a fall a resident experienced which resulted in a significant change in their health status.

In accordance with the Long-Term Care Homes Service Accountability Agreement under the Local Health Integration Act, 2006, the licensee is required to meet the practice requirements of RAI-MDS.

In accordance with RAI-MDS practice requirements any significant change in a resident's condition either decline or improvement, shall be reassessed along with Resident Assessment Protocols (RAPS) by the interdisciplinary team using the MDS Full Assessment by the 14th day following the determination that a significant change in status had occurred.

The resident experienced a fall which resulted in injuries. As a result of the injuries the resident experienced pain that required the uses of additional medications. The resident also experienced changes in four areas related to their functional abilities.

A Registered Nurse who co-ordinates RAI-MDS activities in the home acknowledged that a significant change assessment should have been completed for the resident based on the changes in their activities of daily living and confirmed that this assessment had not been completed.

The failure of staff to complete a significant change RAI-MDS assessment increased the risk that the change in care needs required by the resident would not be fully assessed and plans of care not developed to meet the new needs of the resident.

Sources: a Critical Incident Report, Long-Term Care Homes Service Accountability Agreement (LSAA) under the Local Health Integration Act, 2006, RAI-MDS 2.0 Canadian Version User's Manual and an interview with a RN.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that every licensee complies with the conditions to which the licensee is subject, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

The licensee failed to ensure that the Director was immediately informed of the improper care provided to a resident that resulted in an injury to the resident.

The DOC initiated an investigation related to an incident during which a resident sustained an injury when PSWs staff performed an unsafe transfer of the resident.

The results of the investigation indicated PSWs performed an unsafe transfer of the resident that resulted in the resident sustaining an injury.

The DOC acknowledged that following their investigation they were aware that PSWs had provided improper and unsafe care to the resident that resulted in an injury to the resident, and they did not notify the Director of this information.

Sources: written statements by two PSW, DOC's investigative notes and an interview with the DOC.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
4. Subject to subsection (3.1), an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition.

Findings/Faits saillants :

The licensee failed to ensure that the Director was informed no later than one business day following an occurrence when a resident fell, which resulted in a significant change in their health status.

The Critical Incident Report (CIR) and the resident's clinical record confirmed the Director was notified of the incident seven business days later when the home submitted the CIR. The CIR indicated the home was submitting the incident as an incident that caused injury to a resident for which the resident was transferred to hospital, and which resulted in a significant change in the resident's health condition.

The DOC acknowledged the CIR was not submitted to the Director within one business day as was required.

Sources: a CIR, a resident's clinical progress notes and an interview with the DOC.

Issued on this 21st day of March, 2022

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2021_857129_0011
Log No. / No de registre :	018849-21, 019426-21
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Mar 14, 2022
Licensee / Titulaire de permis :	955464 Ontario Limited 3700 Billings Court, Burlington, ON, L7N-3N6
LTC Home / Foyer de SLD :	Crescent Park Lodge 4 Hagey Avenue, Fort Erie, ON, L2A-5M5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Rosemary Turner

To 955464 Ontario Limited, 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 :

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

Order / Ordre :

The licensee must be compliant with s. 6(7) of the LTCHA 2007.

Specifically, the licensee must:

-Conduct audits of an identified resident and other residents whose plans of care identified that they require assistance to transfer with the use of a mechanical lift to ensure that care is provided as specified in their plan of care. Auditing is to continue until no further issues are identified and records of the completed audits are to be maintained.

-Conduct audits to ensure directions identified in resident care plans are consistent with the directions for care identified in the Kardex and the bedside guide. Auditing is to continue until no further issues are identified and records of the completed audits are to be maintained.

-Conduct audits of three identified residents to ensure falls interventions identified in their plans of care are provided as specified in the plan. Auditing is to continue until no further issues are identified and records of the completed audits are to be maintained.

-Train all PSWs on the importance of reviewing the Kardex before each shift when working with a new resident or after a resident has experienced a change in their condition or care needs. Training record that includes the names of staff who were trained and the date the training was provided are to be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that four residents were provided with care

in accordance with the directions in their plans of care.

a) The licensee failed to ensure that care set out in a resident's plan of care related to assistance during transfers was provided to the resident as set out in the plan of care.

The resident had been identified at risk for falling. Following assessments of the resident, their care plan was developed and directed that the resident required the assistance of staff for transfers and the use of a mechanical lift.

Two Personal Support Workers (PSWs) confirmed they assisted the resident to stand, the resident was unable to continue to stand and fell, which resulted in the resident receiving an injury.

The Physiotherapist confirmed that due to the resident's unreliable ability to stand and bear their own weight, only Physiotherapist Assistants were authorized to stand the resident.

The Resident Assessment Instrument (RAI) Coordinator confirmed the resident's care plan did not include directions that PSWs were to assist the resident to stand during transfers.

During an interview one PSW confirmed that they had not reviewed the care plan or Kardex prior to providing care to the resident, and they were not aware of the directions in the care plan related the type of assistance the resident required to transfer.

The care specified in the resident's care plan related to assistance to transfer was not provided to the resident at the time of this incident.

The failure of staff to ensure the resident received the care that had been specified in the care plan related to assistance to transfer resulted in the resident sustaining an injury when they fell.

Sources: the resident's electronic care plan, written statements by to PSWs, a Critical Incident Report and interviews with a PSW, the Physiotherapist and the RAI Coordinator.

b) The licensee has failed to ensure that care specified in a second resident's plan of care related to falls prevention was provided as specified in the plan, specifically, the use of a chair alarm and ensuring the call bell was accessible to the resident.

The resident had been identified at risk for falling and care plan interventions to manage the risk included ensuring the call bell was accessible to the resident and a chair alarm was to be used to remind the resident to wait for assistance of staff before leaving their chair.

During the inspection it was observed that the resident was sitting in their room and the call bell was not accessible to them. At this time the resident attempted to reach the call bell that was lying on a chair that had been positioned behind the resident and they acknowledged that they were not able to reach the call bell.

At this time, it was also observed that a chair alarm did not appear to be in use.

A PSW was asked to attend to the resident, and they confirmed that a chair alarm had not been put in place.

The failure of staff to ensure that care plan interventions identified in the resident's plan of care were in place related to the call bell and a chair alarm, increased the risk that the resident would attempt to leave their chair and fall.

Sources: the resident's electronic care plan, observations of the resident and interviews with the resident and a PSW.

c) The licensee has failed to ensure that care specified in a third resident's plan of care related to falls prevention was provided as specified in the plan, specifically, that the call bell was placed within reach of the resident.

The resident had been identified at risk for falling and care plan interventions to manage the risk included ensuring the call bell was accessible to the resident.

At the time of this inspection, it was observed that the resident was in bed and a

family member was in the room. It was observed that the resident's call bell cord had been wrapped around the underside of the bed frame and the resident would not have been able to access the call bell to call for assistance. Both the family member and a PSW, who were in the room at the time, confirmed that the resident would not have been able to reach the call bell to call for assistance.

The resident's care plan indicated the call bell was to be accessible to the resident as a fall prevention strategy and that the resident was able to call for assistance using the call bell.

The failure of staff to ensure that care plan interventions identified in the resident's plan of care were in place related to the accessibility of the call bell, increased the risk that the resident would attempt to self-ambulate and fall.

Sources: Observations of the resident in their room, the resident's electronic care plan and interviews with the family member and a PSW.

d) The licensee failed to ensure care specified in a fourth resident's plan of care related to falls prevention was provided as specified in the plan, specifically, that the call bell was placed within reach of the resident.

The resident had been identified at risk for falling and care plan interventions to manage the risk included, ensuring the call bell was accessible to the resident.

At the time of this inspection, it was observed that the resident was sitting in their room and did not have access to the call bell. A PSW who was in the room at the time of the observation acknowledged that the resident did not have access to the call bell.

The failure of staff to ensure that care plan interventions identified in the resident's plan of care were in place related to the accessibility of the call bell, increased the risk that the resident would attempt to self-ambulate and fall.

Sources: Observations of the resident, the resident's electronic care plan and an interview with a PSW.

An order was made by taking the following factors into account:

Severity: Residents were not provided with care as specified in their plans of care related to falls prevention interventions. There was actual harm when a resident was not transferred in accordance with the directions in their plan of care and they fell resulting in an injury. There was an actual risk of harm that three additional residents would attempt to self-ambulate and fall when they did not have access to the call bell to call for assistance and when one of the residents also did not have a chair alarm in place as directed in their plans of care.

Scope: The scope of this non-compliance was widespread because care as specified in plans of care was not provide to four of four residents who were reviewed during this inspection.

Compliance History: Three written notifications (WN) and six voluntary plans of corrective action (VPC) were issued to the home related to different parts of the legislation in the past 36 months.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2022

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 : 002

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

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) of O. Reg. 79/10.

Specifically, the licensee shall prepare, submit, and implement a plan to ensure when bed rails are used, the resident is assessed, and their bed system is evaluated in accordance with prevailing practices. The plan must include but is not limited to:

-Actions taken to develop and implement an interdisciplinary bed safety assessment that includes relevant questions and guidance related to the individual resident assessment identified in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U. S. F.D.A., April 2003 guidance document.

-Actions taken for the review and where necessary the revision of the licensee's "Bed Rails-Safe Use and Entrapment Risk Management" policy to ensure the policy reflects the guidance and directions identified in clinical guidance documents.

-The type of retraining involved, including who will be responsible for the training and when it will be completed.

-A process and schedule for the completion of bed safety assessments and bed system evaluations for the four identified residents and all other residents who use bed rails.

-Actions that must be taken when a bed system evaluation identified failed entrapment zone testing.

-The person(s) responsible for monitoring that bed safety assessments and bed system evaluations are completed in accordance with the new assessment tool and the licensee's policy.

-The person(s) responsible for implementing an action plan if monitoring demonstrates the resident bed safety assessment or the bed system evaluation have not been completed in accordance with the new assessment tool and the licensee's policy.

-The person(s) responsible for the review and where necessary the revision of the home's existing process when providing education to residents and family related to the use of bed rails.

Please submit the written plan for achieving compliance for inspection #2021_857129_0011 to Phyllis Hiltz-Bontje, LTC Homes Inspector, MLTC by email to HamiltonSAO.moh@ontario.ca by March 24, 2022.

Please ensure that the submitted plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure that when bed rails were used for four residents that the residents were assessed, and their bed systems were evaluated in accordance with prevailing practices.

The following documents had been provided to all long-term care home Administrators to be used as best practice documents in Long-Term Care homes: "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" developed by the Hospital Bed Safety Workgroup and "Adult Hospital Beds: Patient

Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" published by Health Canada.

The DOC confirmed the bed rail assessment used in the home was part of a safety assessment identified as "Safety Assessment-Fall Risk-Restraints, and Bed Rails-V2", which was completed electronically.

The bed rail use clinical assessment process used in the home was reviewed and it was determined that it was not developed fully in accordance with the prevailing practice documents.

The DOC explained that before, when the home used the Safety Assessment, they would use this tool to complete bed rail assessment and acknowledged that since they had changed to the Falls Risk Assessment Tool (FRAT) tool to assess the risk for falls they had not been completing assessments of the resident prior to the application of bed rails.

a) On two dates a resident was observed to be in bed and appeared to be sleeping. On both occasions it was observed that the resident was in an unusual position with their head angled sharply towards a half-length bed rail that was in the up position on the right side of the bed. This safety concern was brought to the attention of staff who attended the resident.

The resident's plan of care indicated the use of bed rails were implemented on the day the resident was admitted, at the request of the resident and a family member. Directions to use half-length bed rails on both sides of the bed when the resident was in bed for bed mobility was added to the care plan. The plan of care also identified the following care requirements: staff assistance for bed mobility, was at risk for falling and assistance of staff with a mechanical lift for transfers was required.

A review of the assessment process confirmed it did not incorporate a process by which the resident's sleep patterns, habits and behaviours could be evaluated or observed while sleeping in bed with or without the application of bed rails, as identified in the prevailing practice guidance documents. The licensee's policy "Bed Rails-Safe Use And Entrapment Risk Management" dated November 2017, directed the Safety assessment was to be completed upon admission and

did not direct staff to observe the resident for sleep patterns, habits, or behaviours before entering data on the Safety assessment.

The resident's safety assessment was completed on the day of admission and registered staff who completed the assessment documented the resident's sleep patterns and sleep preferences were unknown because the resident was a new admission and the assessment did not identify the conclusion reached, related to the use of bed rails, based on the assessment that was completed.

According to the assessment, both the resident and a family member requested the use of bed rails, they had signed the "Living at Risk" form and the request for bed rails was made following the provision of education to the resident and the family member. The assessment did not identify a conclusion based on information collected and the use of two half bed rails were implemented on the day the resident was admitted to the home. The licensee followed the request of the resident and the family member without balancing the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the legislation.

The assessment form did not include a section that could be completed by the assessor indicating what bed rail alternatives were trialed prior to applying the bed rails, as identified in the prevailing practice documents. According to the resident's plan of care, bed rails were used as a personal assistive device related to bed mobility, however, alternatives to the use of bed rails such as transfer pole, raised perimeter mattress or adjustable bolsters had not been considered.

The questions included on the assessment form did not include key questions related to medication use. Relevant questions were noted to include resident overall mobility, falls history bed rail use concerns such as attempts to transfer toilet self while lacking ability to safely do so and history of entrapment. However, when answered with a "yes" or a "no", the form did not provide direction to registered staff. The assessment form did not include a conclusion section for the assessor to identify if bed rails were recommended or not recommended and the reasons based on the outcome of the observation period and responses to questions. No conclusion related to the use of bed rails for the resident was documented.

There was no evidence to indicate that the resident had been assessed or their bed system evaluated prior to the use of bed rails.

The failure to complete a bed rail safety assessment and a bed system evaluation in accordance with prevailing practices increased the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: Observations of the resident and their bed system, the resident's care plan, "Safety Assessment-Fall Risk-Restraints, and Bed Rails-V2" document, “Safety Assessment, “Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003",“Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008”,Joerns Bed Safety Audit, licensee's "Bed Rails-Safe Use And Entrapment Risk Management" policy and interview with DOC.

b) At the time of this inspection a second resident was noted to have two stationary assist bed rails in place a quarter the way down from the head of the bed on both sides of the bed.

The resident's plan of care indicated the use of bed rails were implemented.

There was no evidence in the clinical record or records provided by the home to confirm that the resident had been assessed and their bed system evaluated prior to the use of bed rails.

The resident was not assessed, and their bed system was not evaluated prior to bed rails being applied to their bed and their use included in the resident’s care plan.

The failure to complete a bed rail safety assessment and a bed system evaluation in accordance with prevailing practices increased the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: the resident's care plan, observation of the resident bed system and an interview with the DOC.

c) At the time of this inspection a third resident was noted to have two 1/4 length bed rails in place on both sides of the bed.

The resident's care plan indicated the use of bed rails were implemented at the request of the resident's family member and consent for acceptance of resident risk had been signed by the family member.

A "Safety Assessment-Fall Risk, Restraint and Bed Rail -V3" assessment document completed four months prior to the inspection indicated that bed rails were not in use.

There was no evidence in the clinical record or records provided by the home to confirm that the resident had been assessed and their bed system evaluated prior to the use of bed rails.

The resident was not assessed, and their bed system was not evaluated prior to the bed rails being applied to their bed and included in their care plan.

The failure to complete a bed rail safety assessment and a bed system evaluation in accordance with prevailing practices increased the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: the resident's care plan, observation of the resident and their bed system bed system and an interview with the DOC.

d) At the time of this inspection a fourth resident was noted to have two full length bed rails in place and in use by the resident.

The resident's plan of care indicated bed rails were implemented.

A "Safety Assessment-Fall Risk, Restraint and Bed Rail -V3" assessment had not been completed for the resident.

There was no evidence in the clinical record or records provided by the home to confirm that a bed rail assessment and a bed system evaluation had been completed for the resident.

The resident was not assessed, and their bed system was not evaluated prior to bed rails being applied to their bed and included in their care plan.

The failure to complete a bed rail safety assessment and a bed system evaluation increased the risk that the resident could be harmed by becoming entrapped when bed rails were used.

Sources: the resident's care plan, observation of the resident and their bed system bed system and an interview with the DOC.
(129)

2. The licensee failed to take steps to prevent resident entrapment when they did not take immediate action when it was identified that several resident beds had failed entrapment zone testing.

An audit of bed safety conducted by a representative from a bed supply company on September 22, 2021, identified that eight beds had failed entrapment zone testing for zones six and seven.

The written audit record also contained handwritten entries made by a maintenance person that included check marks in the additional note section of the audit form for the eight identified beds and a handwritten entry on a blank portion of the document that indicated “Failed parts corrected December 6, 2021”.

The failure of staff to immediately correct and document the correction of beds that failed entrapment zone testing increased the risk of injury and possible entrapment for the residents who may have been using the failed beds or residents who may be moved into those beds.

Sources: a Bed Safety Survey document and interview with the DOC.

An order was made by taking the following factors into account:

Severity: Assessments of the residents and evaluations of their bed systems were not completed in accordance with prevailing practices when bed rails were

used and bed repairs for beds that had failed entrapment zone testing were not completed in a timely manner. There was an actual risk of harm that four residents could be injured or entrapped by the bed rails.

Scope: The scope of this non-compliance was widespread because bed rail assessments were not completed in accordance with prevailing practices, bed system evaluations had not been completed for four of four residents and repairs to beds that had not passed entrapment zone tested were not completed in a timely manner for eight of eight beds.

Compliance History: Three written notifications (WN) and six voluntary plans of corrective action (VPC) were issued to the home related to different parts of the legislation in the past 36 months.
(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2022

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with s. 36 of O. Reg. 79/10.

Specifically, the licensee must:

-Provide training to PSWs related to safe transferring techniques. Training records that include the date(s) training was provide and the names of staff who attended the training, are to be maintained.

-Audit transfers being completed for residents to ensure the techniques used are appropriate and safe for the resident. Auditing is to continue until no further issues arise and audit records are to be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when they assisted a resident who had fallen.

Staff did not use safe transferring techniques when they assisted a resident who had fallen.

The resident's care plan indicated they had reduced mobility and the Physiotherapist had identified that the resident was not able to stand and required the use of a mechanical lift for transfers, which was identified in the resident's plan of care.

Two PSWs confirmed that the resident was unable to bear their weight when they assisted the resident to stand.

Both PSWs indicated that they attempted unsuccessfully to manually lift the resident into a chair and then lowered the resident to the floor. A third PSW was called to assist, and the resident was manually lifted by the staff from the floor into a chair without first being assessed for injuries by a registered nurse. The PSWs indicated that on both occasions they transferred the resident by looping their arm under each arm of the resident and manually lifted the resident.

The transfer technique used by the PSWs resulted in the total weight of the resident's body supported solely by the resident's shoulders during the attempted transfer into the chair as well as when they manually lifted the resident from the floor.

Clinical notes indicated that in the morning following the incident the resident complained of pain which required the administration of pain medication, and an x-ray report indicated the resident had sustained an injury.

During an interview with the resident, they confirmed they still had pain form their injury, sometimes it is worse than other times and they receive medications that sometimes helps.

The DOC acknowledged that the care of the resident by the PSWs was not appropriated or safe, the PSWs had not followed the resident's care plan or directions contained in the licensees polices when they performed transfers of the resident.

The failure of staff to implement safe transfer techniques resulted in the resident experiencing pain from an injury that resulted in a significant change in their health status.

Sources: Interview with the resident, the resident's medical history and clinical progress notes, an x-ray report, written statements by two PSWs and interviews with the Physiotherapist and the DOC.

An order was made by taking the following factors into account:

Severity: A resident was not safely transferred from the floor and into a chair in accordance with their plan of care when they fell. There was actual harm to the

resident when the transfer technique used by staff resulted in the resident experiencing an injury.

Scope: The scope of this non-compliance was isolated because at the time of this inspection one resident was transferred in an unsafe manner when they fell.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg. 79/10 s. 36 and a Voluntary Plan of Correction (VPC) was issued to the home. Three written notifications (WN) and five VPCs were issued to the home related to different parts of the legislation in the past 36 months.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 04, 2022

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
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 14th day of March, 2022

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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