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

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

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

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2019	2019_625133_0005 (A2)	028649-18	Follow up

Licensee/Titulaire de permis

Corporation of the City of Cornwall
360 Pitt Street CORNWALL ON K6J 3P9

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

Glen-Stor-Dun Lodge
1900 Montreal Road CORNWALL ON K6H 7L1

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

Amended by JESSICA LAPENSEE (133) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Upon request from the licensee, the compliance order due date has been amended. The compliance order due date was September 13, 2019. The compliance order due date has been extended to December 13, 2019.

Issued on this 12nd day of September, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 12, 2019	2019_625133_0005 (A2)	028649-18	Follow up

Licensee/Titulaire de permis

Corporation of the City of Cornwall
360 Pitt Street CORNWALL ON K6J 3P9

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

Glen-Stor-Dun Lodge
1900 Montreal Road CORNWALL ON K6H 7L1

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

Amended by JESSICA LAPENSEE (133) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 5, 6, 7, 8, 2019

The following intake was completed in the Follow Up inspection: Log #028649-18 was related to bed rail use.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Staff Development, Health and Safety, and Infection Prevention and Control Officer, maintenance workers, registered and non-registered nursing staff, and residents.

During the course of the inspection, the Inspector observed residents' bed systems, observed identified residents in bed with bed rails in use, observed entrapment zone testing conducted by a maintenance worker, reviewed documentation related to bed system evaluations, reviewed resident's health care records.

The following Inspection Protocols were used during this inspection:
Safe and Secure Home

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

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

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

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

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order (CO) #001 from inspection #2018_619550_0015. The CO was served in October 2018, with a compliance date of February 12, 2019. The CO was amended, as per request from the licensee, on February 11, 2019. The amendment was in relation to the compliance date, which was extended to March 01, 2019.

The licensee was specifically ordered to:

1. Re-evaluate all bed systems where bed rails are used in the home, accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). In consideration of rotating assist rails, all intermediate positions are to be evaluated. The zone specific test results are to be documented.

2. Maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident and which reflects the most recent evaluation for each bed system. Ensure that a re-evaluation of a bed systems is completed as required, such as when a new bed system is created as a result of a change or replacement of components.

3. Review the plan of care of resident #006, #016, #026 and any other residents who are using bed rails to ensure that when a bed rail assessment demonstrated that the resident did not qualify for the use of bed rails, the resident's risk for entrapment is identified in the plan of care with specific interventions to mitigate those risks.

4. Develop and implement a documented ongoing auditing process to ensure that all requirements of this compliance order are satisfied.

The licensee completed step 2. The licensee completed step 4 in that an quarterly auditing process had been developed and initiated, yet it had not been fully implemented. It is noted that an audit was planned for May 2019.

The licensee failed to complete steps 1 and 3.

The licensee failed to complete step 1 in CO #001 in that all bed systems were not re-evaluated in accordance with the HC guidance document, including testing the assist rails in the back position.

The licensee failed to complete step 3 in CO #001 in that where bed rails were in use, for resident #002, #005, #006 and #007, the resident's care plan did not make reference to bed rail use or the care plan specified that bed rails were not in use. For resident #004, the care plan reflected that only one bed rail was in use when two bed rails were in use, the resident's risk of entrapment was not identified in the care plan, and there were no listed interventions to mitigate the resident's risk of entrapment. For resident #001, referenced as resident #026 in CO #001, the care plan did indicate that bed rails were in use and that the resident was at increased risk of entrapment. The listed interventions included placing the call bell within the resident's reach, yet the resident was unable to use their call bell. The other two residents specifically referenced in CO#001 did not resident in the home at the time of the inspection.

In relation to evidence based and prevailing practices:

In August, 2012, the Ministry of Health and Long-Term Care issued a memo to all Long-Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the HC guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" was to be used by all homes as a best practice document. The HC guidance document identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The HC guidance document includes the titles of two additional companion documents. The referenced companion documents are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is a clinical practice guideline, titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit

assessment documented within the resident's health care record, and approval by the team if bed rails are to be used.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to the residents:

On March 6th, 2019, as a result of discussion with, and demonstration by, maintenance worker #103, it was determined that all residents' bed systems had not been tested in accordance with the HC guidance document. The following specific issues were identified: Bed covers such as blankets and comforters had not been removed prior to performing the zone testing; the assembled cone and cylinder tool was used for all of the zone testing when only zone four is to be tested with the assembled tool; the zone four test was done backwards, with the cylinder on the mattress and the cone off the mattress; and, none of the rotating assist rails had been tested in the back (transfer) stopping position which was an express requirement of the compliance order.

On March 6th, 2019, when resident #003's bed system was tested in accordance with the HC guidance document by maintenance worker #103, it was determined that zones three and four failed. Resident #003's bed system included an identified brand of bed frame, an identified type of mattress, and an identified type of bed rail. Maintenance worker #103 indicated that this bed system had been deemed to pass entrapment testing for zones three and four when last tested in February 2019. In a second identified bedroom, maintenance worker #103 tested the bed system in place which included an identified brand of bed frame, an identified type of mattress, and an identified type of bed rail. Zone four failed the testing.

On March 7th, 2019, a new bed system was put into use for resident #003. The new bed system included a new frame, the same mattress, and rotating assist rails. Maintenance worker #103 demonstrated entrapment zone testing for the rotating assist rails in the down (guard) and up (assist) locking positions and all tests were a pass. In the back (transfer) position, zone three passed. Positioning the rail in the back (transfer) position appeared to also create a zone 4. It was tested as such and failed when the bed was at a certain height. The HC Guidance document did not include direction on this type of rail in the back position, only indicating that all rails are to be tested in all intermediate stopping and locking positions. The licensee was advised to seek guidance from Health Canada and

from the bed manufacturer.

On March 7th, 2019, the bed rails were removed from the bed system in the second identified bedroom.

In summary, it was determined that where bed rails are used, the residents' bed systems had not been evaluated in accordance with evidence based practices, to minimize risk to the residents.

Related to the assessment of residents, where bed rails are used, in accordance with prevailing practices to minimize risks to the residents:

As per the FDA clinical guidance document: Decisions to use or discontinue use of bed rails is to be made in the context of an individual resident assessment using an interdisciplinary team with input from the resident and family or the resident's legal representative. The factors to be included in the resident assessment are prescribed. Following the resident assessment, a risk benefit assessment (as prescribed) is to be documented in the resident's health care record. The use of bed rails is to be based on the resident's assessed medical needs, documented clearly and approved by the interdisciplinary team. If clinical and environmental interventions have proven unsuccessful in meeting the residents assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used.

On March 6, 2019, the Inspector interviewed the Staff Development, Health and Safety, and Infection Prevention and Control Officer (the lead, #110), who identified that they had had the lead for assessing residents for bed rail use in response to the Compliance Order. The lead indicated that they could not identify evidence based practices or prevailing practices with which the residents had been assessed, as the "bed rail assessment" form (assessment form) that was in use had come from another LTC home in which they previously worked. The lead indicated they were not aware of the FDA clinical guidance document. The lead explained that in order to complete the assessment form, they sought out information from nursing staff, reviewed the resident's health care record and observed the resident in bed where possible. The lead indicated that there was no interdisciplinary team established to assess the residents or to review all the information that they had gathered. The lead indicated that the although the form

included the question "what alternatives have been trialed", the answers to this question related to interventions used in addition to bed rails (i.e high low bed, floor mat) as opposed to interventions trialed instead of bed rails. As well, it was noted that the form does not include consideration of alternatives to bed rails, where a trial has not been possible. The lead indicated that the assessment form did not bring them to complete a risk benefit assessment upon which a final conclusion about bed rail use would occur. The lead indicated that it was them, and not an interdisciplinary team, that had ultimately approved the use/continued use of bed rails upon completion of the assessment form. Related to the assessment form, the lead explained that answering any of the questions with a "Yes" in section 2, or "No" in section 3, resulted in a determination that the resident did not qualify for bed rail use as the resident would be at increased risk of entrapment. The lead explained that this determination did not imply that bed rails would not be used for a resident. The lead explained that that this determination required the resident or substitute decision maker be made aware of the significant risk of bed entrapment, consent obtained, and the resident's care plan reflected as such. The lead explained the care plan was to include safety interventions, such as placing beds in lowest position, use of a falls mat on the floor next to the bed, locking the wheels on the bed to ensure it remained stationary, and ensuring the call bell was within reach of the resident. The lead acknowledged that while these interventions may help to mitigate the effect of an entrapment event, they would not help to prevent an entrapment event.

In summary, it was determined that the home's assessment and decision making process regarding bed rail use was not in accordance with the prevailing practices outlined in the FDA clinical guidance document.

Related to the assist rails on the residents' beds that are referenced below:

It is to be noted that the assist rails rotate and have two locking positions, up (assist) and down (guard) position. The assist rails also have a stopping position, which is the back (transfer) position. When a bed is at certain height and the rail is back, a portion of the rail remains above the surface of the mattress and as such is considered in use as it presents a potential risk of entrapment, as do the two locking positions.

Resident #001:
On March 7th, 2019, the Inspector observed the resident's bed system and noted

the right assist rail was back and the left assist rail was up. While in the resident's room, Personal Support Worker (PSW) #109 indicated that when the resident was in their bed, both rails were always up.

On March 8, 2019, the lead (#110) indicated they had completed the resident's assessment on February 28, 2019. The conclusion was that the resident did not qualify for bed rail use due to their increased risk of entrapment. The lead decided that two bed rails would remain in use for the resident. The lead indicated that the risk of using bed rails was higher than the risk of not using them for resident #001. It was verified that the resident's care plan did reflect the bed rail use. The care plan specified three related interventions, including one related to the resident's call bell. It was ascertained, through discussion with the lead and PSW #111, that the resident was not able to use their call bell due to the resident's health condition.

Resident #002:
On March 5, 2019, the Inspector observed the resident's bed system and noted that both assist rails were in the up position. While in the resident's bedroom, PSW #104 indicated to the Inspector the resident #002's bed rails always remained in the observed position, when the resident was in bed or not. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that no bed rails were to be in use.

On March 6, 2019, the Inspector observed the resident lying on their bed, with the rails in the previously observed positions.

On March 7th and 8th, 2019, the Inspector observed the resident's bed rails in the previously observed position. While in the resident's bedroom, on March 7, 2019, PSW #109 indicated that the resident's bed rails were always kept in the observed position, and that they considered this to represent that no bed rails were in use. The PSW indicated that if the bed rails were kept in the down positions, then they would consider them in use for resident #002.

On March 8, 2019, the lead (#110) indicated they had begun the resident's assessment on February 28, 2019 and had not completed it. The questions that had been answered led to the determination that the resident did not qualify for bed rail use due to their increased risk of entrapment. The lead indicated that it was their understanding from the logo and the care plan that bed rails were not in use. It was noted that a previous assessment, with an identified date, reflected

that bed rails were not being considered for use. It was verified that the resident's care plan did not include any reference to bed rail use.

Resident #004:
On March 5, 2019, the Inspector observed the resident's bed system and noted that, when facing the bed, the left side assist rail was in the down position and the right side assist rail was in the up position. While in the resident's bedroom, PSW #105 indicated to the Inspector that resident #002's bed rails always remained in the observed position, when the resident was in bed or not. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that only the left bed rail was to be in use.

On March 6, 2019, the Inspector observed the resident lying on their bed, with the rails in the previously observed positions. While in the resident's bedroom, PSW #107 indicated that they had put the right side rail up that morning when they helped the resident get out of bed, and that they should have put the rail back down.

On March 7th and 8th, 2019, the Inspector observed the resident's bed rails in the previously observed position. While in the resident's bedroom, on March 7th, 2019, PSW #109 indicated that when the resident was in their bed, the bed rails were always in the observed position.

On March 8, 2019, the Inspector observed the resident lying on their bed, with the rails in the previously observed positions.

On March 8, 2019, the lead (#110) indicated they had completed the resident's assessment on February 28, 2019. The conclusion was that the resident did not qualify for bed rail use due to their increased risk of entrapment. The lead decided that the left rail would remain in use. The right rail was to be removed, yet that had not yet occurred. It was verified that the resident's care plan specified that the bed rail on an identified side was to be in use when the resident was resting. The care plan did not identify the resident's increased risk of entrapment and did not include any interventions to prevent entrapment in light of the assessed risk. The lead indicated that following review of the resident's assessment with the Inspector, it was clear to them that the risk of having the bed rails in place outweighed any benefits for resident #004. The lead indicated that an interdisciplinary team needed to be brought together to make decisions about bed rail use, and that it could not just be their decision or the decision of a single

person.

Resident #005:
On March 5, 2019, the Inspector observed the resident's bed system and noted that, when facing the bed, the left side assist rail was in the down position and the right side assist rail was in the back position. It was noted that a portion of the right bed rail remained above the surface of the mattress. While in the resident's bedroom, PSW #105 indicated to the Inspector that resident #005's bed rails always remained in the observed position, when the resident was in bed or not. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that no bed rails were to be in use.

It is noted that as per the user manual for the assist rails, entrapment may occur with assist rail in the back or transfer position. The manufacturer specifies "to avoid injury or damage from entrapment: only use the transfer position while attending to the patient; when patient is unattended, return the assist rail to either of the locking positions: guard or assist".

On March 6, 7, 8, 2019, the Inspector observed that the resident's bed rails were in the previously observed position. While in the resident's bedroom, on March 7, 2019, PSW #109 that when the resident was in their bed, the bed rails were always in the observed position.

On March 8, 2019, the lead (#110) indicated they had completed the resident's assessment on February 28, 2019. The conclusion was that the resident did not qualify for bed rail use, due to their increased risk of entrapment. The bed rails were to be removed from the bed, yet that had not yet occurred. It was verified that the resident's care plan specified that no bed rails were to be in use and that the resident did not qualify for bed rail use.

Resident #006:
On March 5, 2019, the Inspector observed the resident's bed system and noted that both assist rails were in the up position. In the resident's bedroom, PSW #105 indicated to the Inspector that resident #006's bed rails always remained in the observed position, when the resident was in bed or not. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that no bed rails were to be in use.

On March 6, 2019, the Inspector observed the resident's bed rails in the

previously observed position.

On March 7th and 8th, 2019, the Inspector observed the resident's bed rails in the previously observed position. In the resident's bedroom, PSW #109 indicated that when the resident was in their bed, the bed rails were always in the observed position.

On March 8, 2019, the lead (#110) indicated they had completed the resident's assessment on February 28, 2019. The conclusion was that the resident did not qualify for bed rail use, due to their increased risk of entrapment. The bed rails were to be removed from the bed, yet that had not yet occurred. It was verified that the resident's care plan specified that no bed rails were to be in use and that the resident did not qualify for bed rail use. The lead indicated that the risk of using bed rails would be higher than of not using them for resident #006.

Resident #007:
On March 5, 2019, the Inspector observed the resident's bed system and noted that both assist rails were in the up position. Resident #007 indicated to the Inspector that the bed rails always remained in the observed position. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that no bed rails were to be in use. Registered Practical Nurse (RPN) #106 indicated to the Inspector that the bed rails should not be up. The RPN confirmed that they had done the resident's admission, including the bed rail assessment, and had concluded that the resident did not require bed rails.

On March 6, 2019, the Inspector observed the resident's bed rails in the previously observed position. PSW #108 indicated that the resident's bed rails were always kept up, noting that they did not think the resident needed bed rails as a result of the resident's physical condition.

On March 7th and 8th, 2019, the Inspector observed the resident's bed rails in the previously observed position. On March 8th, 2019, resident #007 indicated again that their bed rails were always kept in the up position.

In summary, it was determined that where bed rails are used, the residents' had not been assessed in accordance with the prevailing practices outlined in the FDA clinical guidance document, to minimize risk to the resident.

In conclusion, the severity of the issues identified was determined to be a level 2, in that there was the potential for actual harm. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 4, in that non-compliance continues despite the Compliance Order previously issued. Compliance Order #001 was served to the licensee in October 2018, in relation to bed rail use, as a result of Resident Quality Inspection #2018_619550_0015. Consequently, a subsequent compliance order will be served to the licensee. [s. 15. (1) (a)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

Issued on this 12nd day of September, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JESSICA LAPENSEE (133) - (A2)
Inspection No. / No de l'inspection :	2019_625133_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	028649-18 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Sep 12, 2019(A2)
Licensee / Titulaire de permis :	Corporation of the City of Cornwall 360 Pitt Street, CORNWALL, ON, K6J-3P9
LTC Home / Foyer de SLD :	Glen-Stor-Dun Lodge 1900 Montreal Road, CORNWALL, ON, K6H-7L1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steven Golden

To Corporation of the City of Cornwall, you are hereby required to comply with the following order(s) by the date(s) set out below:

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 # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_619550_0015, CO #001;

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

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

Specifically the licensee must:

1. Immediately begin the process of re-evaluating all bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). In consideration of rotating assist rails, intermediate locking and stopping positions are to be evaluated. The zone specific test results are to be documented. The process shall be completed within one month.

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

entrapment when assist rails are in the back stopping position and the bed is at a low height, as observed on resident #003's new bed system and as described in the grounds.

3. Ensure that bed rail use, or removal from use, for residents #001, #002, #004, #005, #006 and #007, and any other resident, is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003)". This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits; medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower than that of other interventions or of not using them.

c) Where bed rails are in use, approval of the use of bed rails for an individual resident by the interdisciplinary team members that conducted the resident's assessment and produced the subsequent risk benefit assessment. The names of the team members, and their approval, is to be clearly documented.

4) Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team. When bed rails are in use, provide clear direction as to what position bed rails are to be used in and when. Include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards resulting from the bed system evaluations.

5) Take steps to prevent resident entrapment, taking into consideration all potential zones of entrapment. This includes, but is not limited to:

a) residents with a bed system that includes an air mattress that cannot pass entrapment zone testing and it has been concluded that the therapeutic benefit outweighs the risk of entrapment;

b) residents who have been provided with one or more bed rails yet assessed to be at risk of entrapment and the interdisciplinary team has concluded that they do not approve of bed rail use.

Steps to prevent resident entrapment shall be taken with consideration of the guidance provided in the two FDA prevailing practices documents previously referenced in this compliance order.

6) Ensure that assist rails are used only in accordance with manufacturer specifications, specifically that assist rails on a bed system only be used in the back, or transfer, position when the resident is being directly attended to by staff. When the resident is unattended, return the assist rail to either of the locking positions.

Grounds / Motifs :

1. 1. The licensee has failed to comply with compliance order (CO) #001 from inspection #2018_619550_0015. The CO was served in October 2018, with a compliance date of February 12, 2019. The CO was amended, as per request from the licensee, on February 11, 2019. The amendment was in relation to the compliance date, which was extended to March 01, 2019.

The licensee was specifically ordered to:

1. Re-evaluate all bed systems where bed rails are used in the home, accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). In consideration of rotating assist rails, all intermediate positions are to be evaluated. The zone specific test results are to be documented.

2. Maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident and which reflects the most recent evaluation for each bed system. Ensure that a re-evaluation of a bed systems is completed as required, such as when a new bed system is created as a result of a change or replacement of components.

3. Review the plan of care of resident #006, #016, #026 and any other residents who are using bed rails to ensure that when a bed rail assessment demonstrated that the resident did not qualify for the use of bed rails, the resident's risk for entrapment is identified in the plan of care with specific interventions to mitigate those risks.

4. Develop and implement a documented ongoing auditing process to ensure that all requirements of this compliance order are satisfied.

The licensee completed step 2. The licensee completed step 4 in that an quarterly auditing process had been developed and initiated, yet it had not been fully implemented. It is noted that an audit was planned for May 2019.

The licensee failed to complete steps 1 and 3.

The licensee failed to complete step 1 in CO #001 in that all bed systems were not re-evaluated in accordance with the HC guidance document, including testing the assist rails in the back position.

The licensee failed to complete step 3 in CO #001 in that where bed rails were in use, for resident #002, #005, #006 and #007, the resident's care plan did not make reference to bed rail use or the care plan specified that bed rails were not in use. For resident #004, the care plan reflected that only one bed rail was in use when two bed rails were in use, the resident's risk of entrapment was not identified in the care plan, and there were no listed interventions to mitigate the resident's risk of entrapment. For resident #001, referenced as resident #026 in CO #001, the care plan did

indicate that bed rails were in use and that the resident was at increased risk of entrapment. The listed interventions included placing the call bell within the resident's reach, yet the resident was unable to use their call bell. The other two residents specifically referenced in CO#001 did not resident in the home at the time of the inspection.

In relation to evidence based and prevailing practices:

In August, 2012, the Ministry of Health and Long-Term Care issued a memo to all Long-Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the HC guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" was to be used by all homes as a best practice document. The HC guidance document identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

The HC guidance document includes the titles of two additional companion documents. The referenced companion documents are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is a clinical practice guideline, titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used.

Related to the evaluation of residents' bed systems, where bed rails are used, in accordance with evidence-based practices to minimize risk to the residents:

On March 6th, 2019, as a result of discussion with, and demonstration by,

maintenance worker #103, it was determined that all residents' bed systems had not been tested in accordance with the HC guidance document. The following specific issues were identified: Bed covers such as blankets and comforters had not been removed prior to performing the zone testing; the assembled cone and cylinder tool was used for all of the zone testing when only zone four is to be tested with the assembled tool; the zone four test was done backwards, with the cylinder on the mattress and the cone off the mattress; and, none of the rotating assist rails had been tested in the back (transfer) stopping position which was an express requirement of the compliance order.

On March 6th, 2019, when resident #003's bed system was tested in accordance with the HC guidance document by maintenance worker #103, it was determined that zones three and four failed. Resident #003's bed system included an identified brand of bed frame, an identified type of mattress, and an identified type of bed rail. Maintenance worker #103 indicated that this bed system had been deemed to pass entrapment testing for zones three and four when last tested in February 2019. In a second identified bedroom, maintenance worker #103 tested the bed system in place which included an identified brand of bed frame, an identified type of mattress, and an identified type of bed rail. Zone four failed the testing.

On March 7th, 2019, a new bed system was put into use for resident #003. The new bed system included a new frame, the same mattress, and rotating assist rails. Maintenance worker #103 demonstrated entrapment zone testing for the rotating assist rails in the down (guard) and up (assist) locking positions and all tests were a pass. In the back (transfer) position, zone three passed. Positioning the rail in the back (transfer) position appeared to also create a zone 4. It was tested as such and failed when the bed was at a certain height. The HC Guidance document did not include direction on this type of rail in the back position, only indicating that all rails are to be tested in all intermediate stopping and locking positions. The licensee was advised to seek guidance from Health Canada and from the bed manufacturer.

On March 7th, 2019, the bed rails were removed from the bed system in the second identified bedroom.

In summary, it was determined that where bed rails are used, the residents' bed systems had not been evaluated in accordance with evidence based practices, to minimize risk to the residents.

Related to the assessment of residents, where bed rails are used, in accordance with prevailing practices to minimize risks to the residents:

As per the FDA clinical guidance document: Decisions to use or discontinue use of bed rails is to be made in the context of an individual resident assessment using an interdisciplinary team with input from the resident and family or the resident's legal representative. The factors to be included in the resident assessment are prescribed. Following the resident assessment, a risk benefit assessment (as prescribed) is to be documented in the resident's health care record. The use of bed rails is to be based on the resident's assessed medical needs, documented clearly and approved by the interdisciplinary team. If clinical and environmental interventions have proven unsuccessful in meeting the residents assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be used.

On March 6, 2019, the Inspector interviewed the Staff Development, Health and Safety, and Infection Prevention and Control Officer (the lead, #110), who identified that they had had the lead for assessing residents for bed rail use in response to the Compliance Order. The lead indicated that they could not identify evidence based practices or prevailing practices with which the residents had been assessed, as the "bed rail assessment" form (assessment form) that was in use had come from another LTC home in which they previously worked. The lead indicated they were not aware of the FDA clinical guidance document. The lead explained that in order to complete the assessment form, they sought out information from nursing staff, reviewed the resident's health care record and observed the resident in bed where possible. The lead indicated that there was no interdisciplinary team established to assess the residents or to review all the information that they had gathered. The lead indicated that the although the form included the question "what alternatives have been trialed", the answers to this question related to interventions used in addition to bed rails (i.e high low bed, floor mat) as opposed to interventions trialed instead of bed rails. As well, it was noted that the form does not include consideration of alternatives to bed rails, where a trial has not been possible. The lead indicated that the assessment form did not bring them to complete a risk benefit assessment upon which a final conclusion about bed rail use would occur. The lead indicated that it was them, and not an interdisciplinary team, that had ultimately approved the

use/continued use of bed rails upon completion of the assessment form. Related to the assessment form, the lead explained that answering any of the questions with a "Yes" in section 2, or "No" in section 3, resulted in a determination that the resident did not qualify for bed rail use as the resident would be at increased risk of entrapment. The lead explained that this determination did not imply that bed rails would not be used for a resident. The lead explained that that this determination required the resident or substitute decision maker be made aware of the significant risk of bed entrapment, consent obtained, and the resident's care plan reflected as such. The lead explained the care plan was to include safety interventions, such as placing beds in lowest position, use of a falls mat on the floor next to the bed, locking the wheels on the bed to ensure it remained stationary, and ensuring the call bell was within reach of the resident. The lead acknowledged that while these interventions may help to mitigate the effect of an entrapment event, they would not help to prevent an entrapment event.

In summary, it was determined that the home's assessment and decision making process regarding bed rail use was not in accordance with the prevailing practices outlined in the FDA clinical guidance document.

Related to the assist rails on the residents' beds that are referenced below:

It is to be noted that the assist rails rotate and have two locking positions, up (assist) and down (guard) position. The assist rails also have a stopping position, which is the back (transfer) position. When a bed is at certain height and the rail is back, a portion of the rail remains above the surface of the mattress and as such is considered in use as it presents a potential risk of entrapment, as do the two locking positions.

Resident #001:
On March 7th, 2019, the Inspector observed the resident's bed system and noted the right assist rail was back and the left assist rail was up. While in the resident's room, Personal Support Worker (PSW) #109 indicated that when the resident was in their bed, both rails were always up.

On March 8, 2019, the lead (#110) indicated they had completed the resident's assessment on February 28, 2019. The conclusion was that the resident did not

qualify for bed rail use due to their increased risk of entrapment. The lead decided that two bed rails would remain in use for the resident. The lead indicated that the risk of using bed rails was higher than the risk of not using them for resident #001. It was verified that the resident's care plan did reflect the bed rail use. The care plan specified three related interventions, including one related to the resident's call bell. It was ascertained, through discussion with the lead and PSW #111, that the resident was not able to use their call bell due to the resident's health condition.

Resident #002:
On March 5, 2019, the Inspector observed the resident's bed system and noted that both assist rails were in the up position. While in the resident's bedroom, PSW #104 indicated to the Inspector the resident #002's bed rails always remained in the observed position, when the resident was in bed or not. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that no bed rails were to be in use.

On March 6, 2019, the Inspector observed the resident lying on their bed, with the rails in the previously observed positions.

On March 7th and 8th, 2019, the Inspector observed the resident's bed rails in the previously observed position. While in the resident's bedroom, on March 7, 2019, PSW #109 indicated that the resident's bed rails were always kept in the observed position, and that they considered this to represent that no bed rails were in use. The PSW indicated that if the bed rails were kept in the down positions, then they would consider them in use for resident #002.

On March 8, 2019, the lead (#110) indicated they had begun the resident's assessment on February 28, 2019 and had not completed it. The questions that had been answered led to the determination that the resident did not qualify for bed rail use due to their increased risk of entrapment. The lead indicated that it was their understanding from the logo and the care plan that bed rails were not in use. It was noted that a previous assessment, with an identified date, reflected that bed rails were not being considered for use. It was verified that the resident's care plan did not include any reference to bed rail use.

Resident #004:
On March 5, 2019, the Inspector observed the resident's bed system and noted that,

when facing the bed, the left side assist rail was in the down position and the right side assist rail was in the up position. While in the resident's bedroom, PSW #105 indicated to the Inspector that resident #002's bed rails always remained in the observed position, when the resident was in bed or not. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that only the left bed rail was to be in use.

On March 6, 2019, the Inspector observed the resident lying on their bed, with the rails in the previously observed positions. While in the resident's bedroom, PSW #107 indicated that they had put the right side rail up that morning when they helped the resident get out of bed, and that they should have put the rail back down.

On March 7th and 8th, 2019, the Inspector observed the resident's bed rails in the previously observed position. While in the resident's bedroom, on March 7th, 2019, PSW #109 indicated that when the resident was in their bed, the bed rails were always in the observed position.

On March 8, 2019, the Inspector observed the resident lying on their bed, with the rails in the previously observed positions.

On March 8, 2019, the lead (#110) indicated they had completed the resident's assessment on February 28, 2019. The conclusion was that the resident did not qualify for bed rail use due to their increased risk of entrapment. The lead decided that the left rail would remain in use. The right rail was to be removed, yet that had not yet occurred. It was verified that the resident's care plan specified that the bed rail on an identified side was to be in use when the resident was resting. The care plan did not identify the resident's increased risk of entrapment and did not include any interventions to prevent entrapment in light of the assessed risk. The lead indicated that following review of the resident's assessment with the Inspector, it was clear to them that the risk of having the bed rails in place outweighed any benefits for resident #004. The lead indicated that an interdisciplinary team needed to be brought together to make decisions about bed rail use, and that it could not just be their decision or the decision of a single person.

Resident #005:
On March 5, 2019, the Inspector observed the resident's bed system and noted that, when facing the bed, the left side assist rail was in the down position and the right

side assist rail was in the back position. It was noted that a portion of the right bed rail remained above the surface of the mattress. While in the resident's bedroom, PSW #105 indicated to the Inspector that resident #005's bed rails always remained in the observed position, when the resident was in bed or not. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that no bed rails were to be in use.

It is noted that as per the user manual for the assist rails, entrapment may occur with assist rail in the back or transfer position. The manufacturer specifies "to avoid injury or damage from entrapment: only use the transfer position while attending to the patient; when patient is unattended, return the assist rail to either of the locking positions: guard or assist".

On March 6, 7, 8, 2019, the Inspector observed that the resident's bed rails were in the previously observed position. While in the resident's bedroom, on March 7, 2019, PSW #109 that when the resident was in their bed, the bed rails were always in the observed position.

On March 8, 2019, the lead (#110) indicated they had completed the resident's assessment on February 28, 2019. The conclusion was that the resident did not qualify for bed rail use, due to their increased risk of entrapment. The bed rails were to be removed from the bed, yet that had not yet occurred. It was verified that the resident's care plan specified that no bed rails were to be in use and that the resident did not qualify for bed rail use.

Resident #006:
On March 5, 2019, the Inspector observed the resident's bed system and noted that both assist rails were in the up position. In the resident's bedroom, PSW #105 indicated to the Inspector that resident #006's bed rails always remained in the observed position, when the resident was in bed or not. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that no bed rails were to be in use.

On March 6, 2019, the Inspector observed the resident's bed rails in the previously observed position.

On March 7th and 8th, 2019, the Inspector observed the resident's bed rails in the

previously observed position. In the resident's bedroom, PSW #109 indicated that when the resident was in their bed, the bed rails were always in the observed position.

On March 8, 2019, the lead (#110) indicated they had completed the resident's assessment on February 28, 2019. The conclusion was that the resident did not qualify for bed rail use, due to their increased risk of entrapment. The bed rails were to be removed from the bed, yet that had not yet occurred. It was verified that the resident's care plan specified that no bed rails were to be in use and that the resident did not qualify for bed rail use. The lead indicated that the risk of using bed rails would be higher than of not using them for resident #006.

Resident #007:
On March 5, 2019, the Inspector observed the resident's bed system and noted that both assist rails were in the up position. Resident #007 indicated to the Inspector that the bed rails always remained in the observed position. The bed rail assessment logo on the resident's whiteboard, with an identified date, reflected that no bed rails were to be in use. Registered Practical Nurse (RPN) #106 indicated to the Inspector that the bed rails should not be up. The RPN confirmed that they had done the resident's admission, including the bed rail assessment, and had concluded that the resident did not require bed rails.

On March 6, 2019, the Inspector observed the resident's bed rails in the previously observed position. PSW #108 indicated that the resident's bed rails were always kept up, noting that they did not think the resident needed bed rails as a result of the resident's physical condition.

On March 7th and 8th, 2019, the Inspector observed the resident's bed rails in the previously observed position. On March 8th, 2019, resident #007 indicated again that their bed rails were always kept in the up position.

In summary, it was determined that where bed rails are used, the residents' had not been assessed in accordance with the prevailing practices outlined in the FDA clinical guidance document, to minimize risk to the resident.

In conclusion, the severity of the issues identified was determined to be a level 2, in

that there was the potential for actual harm. The scope of the issues identified was widespread, at level 3. The home had a compliance history of 4, in that non-compliance continues despite the Compliance Order previously issued. Compliance Order #001 was served to the licensee in October 2018, in relation to bed rail use, as a result of Resident Quality Inspection #2018_619550_0015. Consequently, a subsequent compliance order will be served to the licensee. [s. 15. (1) (a)] (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 13, 2019(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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:

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 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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère 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 12nd day of September, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JESSICA LAPENSEE (133) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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