Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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 rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2021	2021_617148_0019 (A1)	006929-21	Follow up

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 Brockville ON K6V 5T1

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

St. Lawrence Lodge
1803 County Road, #2 East Postal Bag #1130 Brockville ON K6V 5T1

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

Amended by AMANDA NIXON (148) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Acting Administrator Lisa Harper requested extension of CDD to January 28 2022. The report has been updated to reflect this request.

Issued on this 30th day of November, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2021	2021_617148_0019 (A1)	006929-21	Follow up

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1803 County Road, #2 East Postal Bag #1130 Brockville ON K6V 5T1

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

Amended by AMANDA NIXON (148) - (A1)

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): September 7, 8, 13-17, 2021

This inspection included a follow up (Log 006929-21) related to a Compliance Order issued April 21, 2021 related to the use of bed rails in the home.

Inspector Gillian Chamberlin (#593) was on site September 7 and 8, 2021, shadowing Inspector #148.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Assistant Directors of Care, Support Services Manager, Environmental Manager, Quality Assurance and Project Lead, Registered Nurses (RN), Registered Practical Nurses (RN), Personal Support Workers (PSW), Housekeeping Aide and residents.

In addition, the inspector reviewed resident health care records, documents related to the infection prevention and control program and air temperature logs and related policies. The inspector observed resident bedrooms and common spaces and resident care and services.

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

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

4 WN(s)
3 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 failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices, to minimize the risk to the resident.

The Bed Safety Assessment was used to assess a resident's use of bed rails. The resident assessment included information gathered by the physiotherapist and nursing managers, primarily through health care record review . Risk factors, related to the sleep environment, were not considered in the resident's assessments; observations of the sleep environment were not included in the resident assessment. Additionally, the assessment of one resident did not include the risk of a known previous incident of bed entrapment and the assessment of another resident did not consider their diagnosis as a risk factor.

For two residents, the assessments included the identification of risks, however, the assessment does not address the steps taken to reduce such risks.

As exampled by two resident assessments, each discipline varied on conclusions of risk, benefit and use of one or two bed rails, including assessments for two residents. Additionally, the assessment of four residents, who were identified to be totally dependent on staff for positioning and bed mobility, did not demonstrate the benefit for use of bed rails in relation to known risks. The information gathered by a nursing manager for two residents, stated the increased risk of entrapment for both residents, however, in both cases a second nursing manager recommended the use of the bed rails without a risk benefit assessment of that

stated risk. The resident assessments demonstrated a lack of interdisciplinary team assessment and interdisciplinary risk benefit assessment. In addition, the decision to continue or discontinue the use of bed rails was made by a nursing manager rather than by the interdisciplinary team.

The resident assessment including the identification of risk, the steps to reduce the known risks, the risk benefit assessment and the decision to continue or discontinue the use of bed rails was not completed in accordance with the Clinical Guidance document, which may place residents at risk for bed entrapment.

Sources: Observations of resident bed systems on two resident home areas, a review of health care records for eight residents and interviews with PSWs, the Acting Director of Care and review of the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings (April 2003). [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

1. The licensee failed to ensure that the plan of care for three residents, set out clear directions to staff for the implementation of care, related to bed rails.

A resident was observed with two bed rails in use, while sleeping. Directions to staff indicated the use of one bed rail with separate directions at the head of bed to use two rails. The plan of care indicated rails to be used for peri care only.

A second resident was observed with two bed rails in use, while sleeping. The plan of care indicated the use of one bed rail for bed mobility and in a separate section of the plan noted the use of two bed rails for repositioning and assistance with care.

A third resident was observed in bed with one bed rail in use. The plan of care indicated the use of one bed rail for assistance with mobility and care while a separate section of the plan of care noted the use of two rails for safety related to the risk of falls.

Direct care staff were unable to clarify the use and/or purpose of bed rails for the above residents.
Unclear directions to staff may result in residents not provided with their required care.

Sources: Health care records and observations of residents and interviews with PSWs. [s. 6. (1) (c)]

2. The licensee failed to ensure that a resident was provided with the care as set out, as specified by the plan, related to the use of bed rails.

The plan of care for a resident sets out that two bed rails are to be used for repositioning and care and that the rails are to be lowered when the resident is in bed alone. The resident was observed in bed resting with two bed rails in use.

The resident has known risks for bed entrapment. The use of bed rails when staff are not present poses an entrapment risk.

Sources: Observation and health record review of the resident [s. 6. (7)]

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 to ensure that the plan of care set out clear directions to staff and that care is provided to residents as set out by the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure air temperatures were measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The air temperature for the required areas including, resident bedrooms and resident common areas, were not measured and documented at least every morning, once every afternoon and once every evening or night.

When steps are not taken to measure and document the air temperatures in the specified areas of the home during the required time frames, it places risk on resident comfort and safety.

Sources: Air temperature records on three resident home areas, interviews with the Quality Assurance Lead and Acting Director of Care. [s. 21. (3)]

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 to ensure that air temperatures are measured and documented as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program, specifically as it relates to additional precautions.

A resident was not provided with contact precautions as indicated by the infection prevention and control program.

Lack of appropriate precautions in this instance may increase the risk of disease transmission among residents and staff.

Sources: Observations of the resident's room, review of the health care record and interviews with a PSW and an RPN. [s. 229. (4)]

2. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program, specifically as it relates to assisting residents to perform hand hygiene before a meal.

Evidenced based practice indicates that staff should assist residents to perform hand hygiene before and after meals. The meal service was observed on a resident home area. Resident hands were not cleaned before the meal. Staff indicated that a process was in place to wash hands after the meal, but not before.

Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (April 2014), observations of the meal service and interviews with PSWs and Acting DOC. [s. 229. (4)]

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 to ensure that staff participate in the implementation of the infection prevention and control program, specifically related to assisting residents with hand hygiene, to be implemented voluntarily.

Issued on this 30th day of November, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMANDA NIXON (148) - (A1)
Inspection No. / No de l'inspection :	2021_617148_0019 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006929-21 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 30, 2021(A1)
Licensee / Titulaire de permis :	The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott c/o St. Lawrence Lodge, 1803 County Road 2, Brockville, ON, K6V-5T1
LTC Home / Foyer de SLD :	St. Lawrence Lodge 1803 County Road, #2 East, Postal Bag #1130, Brockville, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carolyn Zacharuk

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott, 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)

Linked to Existing Order / Lien vers ordre existant: 2021_617148_0014, 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. Regulation 79/10, s.15(1).

Specifically the licensee must:
Ensure that all residents who use bed rails, are assessed in 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" (Food and Drug Administration, April 2003), to minimize risk to the resident.
This includes, but is not limited to:
A documented resident assessment, by an interdisciplinary team, that includes:
i) the identification of risk factors, including those related to sleep environment;
ii) steps to reduce known risks; and
iii) a risk benefit assessment by the interdisciplinary team prior to any decision regarding bed rail use.

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

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices, to minimize the risk to the resident.

The Bed Safety Assessment was used to assess a resident's use of bed rails. The resident assessment included information gathered by the physiotherapist and nursing managers, primarily through health care record review . Risk factors, related to the sleep environment, were not considered in the resident's assessments; observations of the sleep environment were not included in the resident assessment. Additionally, the assessment of one resident did not include the risk of a known previous incident of bed entrapment and the assessment of another resident did not consider their diagnosis as a risk factor.

For two residents, the assessments included the identification of risks, however, the assessment does not address the steps taken to reduce such risks.

As exampled by two resident assessments, each discipline varied on conclusions of risk, benefit and use of one or two bed rails, including assessments for two residents. Additionally, the assessment of four residents, who were identified to be totally dependent on staff for positioning and bed mobility, did not demonstrate the benefit for use of bed rails in relation to known risks. The information gathered by a nursing manager for two residents, stated the increased risk of entrapment for both residents, however, in both cases a second nursing manager recommended the use of the bed rails without a risk benefit assessment of that stated risk. The resident assessments demonstrated a lack of interdisciplinary team assessment and interdisciplinary risk benefit assessment. In addition, the decision to continue or discontinue the use of bed rails was made by a nursing manager rather than by the interdisciplinary team.

The resident assessment including the identification of risk, the steps to reduce the known risks, the risk benefit assessment and the decision to continue or discontinue the use of bed rails was not completed in accordance with the Clinical Guidance document, which may place residents at risk for bed entrapment.

An order was made by taking the following factors into account: Severity: There was risk of harm to residents with bed rails in use, as residents were not provided with a resident assessment, in accordance with prevailing practices. Scope: The scope of this non-compliance was identified as widespread as it was identified that all

residents with bed rails in use have not been provided with a resident assessment, in accordance with prevailing practices. Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10, s. 15 (1) and a Compliance Order was issued to the home on July 13 2021, during inspection #2021_617148_0014 with an amended compliance due date of August 16, 2020.

Sources: Observations of resident bed systems on two resident home areas, a review of health care records for eight residents and interviews with PSWs, the Acting Director of Care and review of the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings (April 2003). [s. 15. (1) (a)] (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 28, 2022(A1)

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
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 30th day of November, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by AMANDA NIXON (148) - (A1)

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

Ottawa Service Area Office
347 Preston St Suite 420
OTTAWA ON K1S 3J4
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 rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 30, 2021	2021_617148_0019 (A1)	006929-21	Follow up

Licensee/Titulaire de permis

The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott
c/o St. Lawrence Lodge 1803 County Road 2 Brockville ON K6V 5T1

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

St. Lawrence Lodge
1803 County Road, #2 East Postal Bag #1130 Brockville ON K6V 5T1

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

Amended by AMANDA NIXON (148) - (A1)

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): September 7, 8, 13-17, 2021

This inspection included a follow up (Log 006929-21) related to a Compliance Order issued April 21, 2021 related to the use of bed rails in the home.

Inspector Gillian Chamberlin (#593) was on site September 7 and 8, 2021, shadowing Inspector #148.

During the course of the inspection, the inspector(s) spoke with the Acting Administrator, Acting Director of Care (DOC), Assistant Directors of Care, Support Services Manager, Environmental Manager, Quality Assurance and Project Lead, Registered Nurses (RN), Registered Practical Nurses (RN), Personal Support Workers (PSW), Housekeeping Aide and residents.

In addition, the inspector reviewed resident health care records, documents related to the infection prevention and control program and air temperature logs and related policies. The inspector observed resident bedrooms and common spaces and resident care and services.

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

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

4 WN(s)
3 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 failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices, to minimize the risk to the resident.

The Bed Safety Assessment was used to assess a resident's use of bed rails. The resident assessment included information gathered by the physiotherapist and nursing managers, primarily through health care record review . Risk factors, related to the sleep environment, were not considered in the resident's assessments; observations of the sleep environment were not included in the resident assessment. Additionally, the assessment of one resident did not include the risk of a known previous incident of bed entrapment and the assessment of another resident did not consider their diagnosis as a risk factor.

For two residents, the assessments included the identification of risks, however, the assessment does not address the steps taken to reduce such risks.

As exampled by two resident assessments, each discipline varied on conclusions of risk, benefit and use of one or two bed rails, including assessments for two residents. Additionally, the assessment of four residents, who were identified to be totally dependent on staff for positioning and bed mobility, did not demonstrate the benefit for use of bed rails in relation to known risks. The information gathered by a nursing manager for two residents, stated the increased risk of entrapment for both residents, however, in both cases a second nursing manager recommended the use of the bed rails without a risk benefit assessment of that

stated risk. The resident assessments demonstrated a lack of interdisciplinary team assessment and interdisciplinary risk benefit assessment. In addition, the decision to continue or discontinue the use of bed rails was made by a nursing manager rather than by the interdisciplinary team.

The resident assessment including the identification of risk, the steps to reduce the known risks, the risk benefit assessment and the decision to continue or discontinue the use of bed rails was not completed in accordance with the Clinical Guidance document, which may place residents at risk for bed entrapment.

Sources: Observations of resident bed systems on two resident home areas, a review of health care records for eight residents and interviews with PSWs, the Acting Director of Care and review of the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings (April 2003). [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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 :

1. The licensee failed to ensure that the plan of care for three residents, set out clear directions to staff for the implementation of care, related to bed rails.

A resident was observed with two bed rails in use, while sleeping. Directions to staff indicated the use of one bed rail with separate directions at the head of bed to use two rails. The plan of care indicated rails to be used for peri care only.

A second resident was observed with two bed rails in use, while sleeping. The plan of care indicated the use of one bed rail for bed mobility and in a separate section of the plan noted the use of two bed rails for repositioning and assistance with care.

A third resident was observed in bed with one bed rail in use. The plan of care indicated the use of one bed rail for assistance with mobility and care while a separate section of the plan of care noted the use of two rails for safety related to the risk of falls.

Direct care staff were unable to clarify the use and/or purpose of bed rails for the above residents.
Unclear directions to staff may result in residents not provided with their required care.

Sources: Health care records and observations of residents and interviews with PSWs. [s. 6. (1) (c)]

2. The licensee failed to ensure that a resident was provided with the care as set out, as specified by the plan, related to the use of bed rails.

The plan of care for a resident sets out that two bed rails are to be used for repositioning and care and that the rails are to be lowered when the resident is in bed alone. The resident was observed in bed resting with two bed rails in use.

The resident has known risks for bed entrapment. The use of bed rails when staff are not present poses an entrapment risk.

Sources: Observation and health record review of the resident [s. 6. (7)]

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 to ensure that the plan of care set out clear directions to staff and that care is provided to residents as set out by the plan of care, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee failed to ensure air temperatures were measured and documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

The air temperature for the required areas including, resident bedrooms and resident common areas, were not measured and documented at least every morning, once every afternoon and once every evening or night.

When steps are not taken to measure and document the air temperatures in the specified areas of the home during the required time frames, it places risk on resident comfort and safety.

Sources: Air temperature records on three resident home areas, interviews with the Quality Assurance Lead and Acting Director of Care. [s. 21. (3)]

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 to ensure that air temperatures are measured and documented as required, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participate in the implementation of the infection prevention and control program, specifically as it relates to additional precautions.

A resident was not provided with contact precautions as indicated by the infection prevention and control program.

Lack of appropriate precautions in this instance may increase the risk of disease transmission among residents and staff.

Sources: Observations of the resident's room, review of the health care record and interviews with a PSW and an RPN. [s. 229. (4)]

2. The licensee has failed to ensure that all staff participate in the implementation of the infection prevention and control program, specifically as it relates to assisting residents to perform hand hygiene before a meal.

Evidenced based practice indicates that staff should assist residents to perform hand hygiene before and after meals. The meal service was observed on a resident home area. Resident hands were not cleaned before the meal. Staff indicated that a process was in place to wash hands after the meal, but not before.

Lack of hand hygiene increases the risk of disease transmission among residents and staff.

Sources: Public Health Ontario - Best Practices for Hand Hygiene in All Health Care Settings, 4th Edition (April 2014), observations of the meal service and interviews with PSWs and Acting DOC. [s. 229. (4)]

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 to ensure that staff participate in the implementation of the infection prevention and control program, specifically related to assisting residents with hand hygiene, to be implemented voluntarily.

Issued on this 30th day of November, 2021 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by AMANDA NIXON (148) - (A1)
Inspection No. / No de l'inspection :	2021_617148_0019 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006929-21 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 30, 2021(A1)
Licensee / Titulaire de permis :	The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott c/o St. Lawrence Lodge, 1803 County Road 2, Brockville, ON, K6V-5T1
LTC Home / Foyer de SLD :	St. Lawrence Lodge 1803 County Road, #2 East, Postal Bag #1130, Brockville, ON, K6V-5T1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carolyn Zacharuk

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To The Corporations of the United Counties of Leeds and Grenville, the City of Brockville, the Town of Gananoque and the Town of Prescott, 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)

Linked to Existing Order / Lien vers ordre existant: 2021_617148_0014, 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. Regulation 79/10, s.15(1).

Specifically the licensee must:
Ensure that all residents who use bed rails, are assessed in 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" (Food and Drug Administration, April 2003), to minimize risk to the resident.
This includes, but is not limited to:
A documented resident assessment, by an interdisciplinary team, that includes:
i) the identification of risk factors, including those related to sleep environment;
ii) steps to reduce known risks; and
iii) a risk benefit assessment by the interdisciplinary team prior to any decision regarding bed rail use.

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

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, the resident was assessed in accordance with prevailing practices, to minimize the risk to the resident.

The Bed Safety Assessment was used to assess a resident's use of bed rails. The resident assessment included information gathered by the physiotherapist and nursing managers, primarily through health care record review . Risk factors, related to the sleep environment, were not considered in the resident's assessments; observations of the sleep environment were not included in the resident assessment. Additionally, the assessment of one resident did not include the risk of a known previous incident of bed entrapment and the assessment of another resident did not consider their diagnosis as a risk factor.

For two residents, the assessments included the identification of risks, however, the assessment does not address the steps taken to reduce such risks.

As exampled by two resident assessments, each discipline varied on conclusions of risk, benefit and use of one or two bed rails, including assessments for two residents. Additionally, the assessment of four residents, who were identified to be totally dependent on staff for positioning and bed mobility, did not demonstrate the benefit for use of bed rails in relation to known risks. The information gathered by a nursing manager for two residents, stated the increased risk of entrapment for both residents, however, in both cases a second nursing manager recommended the use of the bed rails without a risk benefit assessment of that stated risk. The resident assessments demonstrated a lack of interdisciplinary team assessment and interdisciplinary risk benefit assessment. In addition, the decision to continue or discontinue the use of bed rails was made by a nursing manager rather than by the interdisciplinary team.

The resident assessment including the identification of risk, the steps to reduce the known risks, the risk benefit assessment and the decision to continue or discontinue the use of bed rails was not completed in accordance with the Clinical Guidance document, which may place residents at risk for bed entrapment.

An order was made by taking the following factors into account: Severity: There was risk of harm to residents with bed rails in use, as residents were not provided with a resident assessment, in accordance with prevailing practices. Scope: The scope of this non-compliance was identified as widespread as it was identified that all

residents with bed rails in use have not been provided with a resident assessment, in accordance with prevailing practices. Compliance History: In the last 36 months, the licensee was found to be non-compliant with O. Reg 79/10, s. 15 (1) and a Compliance Order was issued to the home on July 13 2021, during inspection #2021_617148_0014 with an amended compliance due date of August 16, 2020.

Sources: Observations of resident bed systems on two resident home areas, a review of health care records for eight residents and interviews with PSWs, the Acting Director of Care and review of the Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospital, Long Term Care Facilities, and Home Care Settings (April 2003). [s. 15. (1) (a)] (148)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 28, 2022(A1)

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
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 30th day of November, 2021 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by AMANDA NIXON (148) - (A1)

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

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