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 le Loi de 2007 les foyers de soins de longue durée

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

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

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Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 17, 2017;	2017_539120_0048 (A1)	018220-17	Critical Incident System

Licensee/Titulaire de permis

YEE HONG CENTRE FOR GERIATRIC CARE
2311 MCNICOLL AVENUE SCARBOROUGH ON M1V 5L3

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

YEE HONG CENTRE - MARKHAM
2780 BUR OAK AVENUE MARKHAM ON L6B 1C9

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date was amended from January 31, 2018 to March 31, 2018.

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 le Loi de 2007 les foyers de soins de longue durée

Issued on this 17 day of October 2017 (A1)

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

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): August 9 & 10, 2017

A critical incident was submitted by the licensee regarding an unexpected death of a resident while in bed.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Resident Care, Environmental Services Supervisor, Occupational Therapist, Physiotherapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers and resident family members.

During the course of the inspection, the inspector toured three separate home areas, observed residents' bed systems and residents in bed, reviewed resident bed safety assessments, bed entrapment zone evaluations, bed safety policies and procedures and resident clinical records.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that, where bed rails were used, that residents were assessed in accordance with prevailing practices to minimize risk to the residents.

According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be clinically assessed by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use. Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer's directions), pass all zones of entrapment (specific areas that are measured around the bed rail and mattress and the bed rail itself), and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. The assessment guideline offers examples of key assessment questions that guides decision-making such as the resident's history of falls from bed, previous bed rail use, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors and the entrapment status

of the resident's bed.

The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (at night only, when requested by resident or with staff assistance), how many bed rails (one, two or four), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's clinical assessment process of residents using bed rails was compared to the assessment guidelines and determined to lack several key components and was therefore not developed in accordance with prevailing practices as identified in the above assessment guideline.

A) The licensee's two policies related to bed safety were reviewed and included "Bed Safety" dated April 2016, and "Safe Use of Bedrails" dated May 2016. No reference was made to the above noted guideline in either policy, however a reference was made to Health Canada's guideline titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008", which references the above noted FDA clinical guidance document. According to the Director of Resident Care, the guideline was not reviewed by himself or the registered nurses (RN) in the home and therefore not fully incorporated into their clinical practices.

As part of their process in assessing the resident, the RNs were directed by their "Safe Use of Bedrails" policy to use a form titled "Bed Rail Need Assessment" (BRNA) and the procedures included the need to "evaluate the resident's use of bed rails quarterly" and to "assess the resident's safety in bed". No specific information was included to define how the resident's safety while in bed was to be

completed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), the length of time resident's would be monitored with or without bed rails, what alternatives need to be trialled before deciding that bed rails are an ideal option and for how long, who would monitor the resident during the night and how often, what specific hazards would be monitored for and subsequently documented and how specifically other team members would participate in assisting the RN in making a final decision about the benefits versus the risks of the resident's bed rail.

The licensee's policy titled "Bed Safety" was geared towards ensuring that the residents' beds were in good condition, passed all zones of entrapment and were inspected on a regular basis. It included the role of the RN/RPN to "monitor resident risks of bed entrapment" and "educate residents and their families about the proper use of bed and side rails" and "be aware of malfunctioning bed components". The policy did not identify how consent would be acquired from the resident or SDM to apply the bed rails and did not identify exactly what information needed to be shared with the SDM or resident with respect to bed rail hazards. No written information regarding the hazards of bed rails was made available to any family member or resident.

B) The BRNA form, which was required to be used upon admission (or with any change in status), was not designed to document what bed related risks were monitored for after admission. Part A was to be completed upon admission by answering questions that the RN would not have been independently aware of (unless the form was used with a change in status after admission). The questions included the resident's risk of entrapment, involuntary body movements, body size, communication level, behaviours increasing risk of falling, behaviours increasing risk for bed entrapment, history of bed entrapment and history of climbing over the bed rails. These questions, when answered were completed with the resident's SDM, before the resident spent one night in bed after admission, as identified with resident #100 below. The form did not include a section that included information gathered by an interdisciplinary team of staff who were tasked at monitoring the resident in bed, over a period of time, with and without the bed rails. Examples of questions to assist decision making around the hazards of bed rail use include but are not limited to bed rail injuries (banging into or against the rail), sleeping habits (if the resident was restless, frequently exited the bed, was in pain, had a sleep disorder, hallucinations, delirium, slept next to a rail, or along edge of bed), if body parts went through the rail, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed

related components such as a bed remote and their bed mobility and transfer capabilities.

The BRNA form included an alternatives section for completion by the RN, however the options on the form included interventions such as bed alarm, fall prevention mat, hi low bed and toileting, turning and repositioning schedules. The interventions are typically applied with or without bed rails in place. No bed rail alternatives were listed such as perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters.

C) According to the RN who completed the assessments using the BRNA form, an interdisciplinary team approach was taken by including the Occupational Therapist (OT) and Personal Support Workers (PSW) in providing information about the resident. The OT reported having a role in assessing the resident's transfer capabilities (in and out of bed) and their general mobility status and the PSWs provided information about the residents' abilities to reposition themselves in bed and their overall activities of daily living (sleeping, eating, dressing, toileting, pain, falls, communication etc.). The staff roles identified and to what extent their input would assist the RN in making decisions about the residents' overall bed safety risks was not included in either of the bed related safety policies. Progress notes were made when the residents were first admitted and a standard "safety check" completed. The safety checks were described as being a basic check, to determine if the resident was in bed, sleeping or awake, and not in any distress. Safety checks are a continuous routine of all staff for all residents, however bed safety hazards are not specifically included with these checks. The bed safety policies did not include specifically what type of bed safety risks or hazards the interdisciplinary team should be monitoring.

D) During the tour of the home in two specific home areas, observations were made that approximately 99 percent of resident beds had at least one bed rail applied, either a quarter length bed rail raised or a rotating assist rail in the guard position (centre of bed). In one home area, the residents were all considered to have cognitive impairment. A random selection of residents were chosen for review, some who were observed in bed at the time of inspection. Although not all of these residents occupied their beds at the time of the observation, the residents all had a plan of care identifying that PSWs were to apply them. According to the RN who completed their assessments, none were identified to have bed rails that were considered a restraint or that had any limiting or inhibiting effects for the resident. To confirm the need for bed rails to be engaged or "raised" while

residents were out of bed, the residents' written plans of care were reviewed.

1. Resident #100 was admitted to the home on a specified date in 2017, and had a bed safety assessment completed on the same date. The RN documented on the BRNA that the resident's sole risk factor for bed safety was their behavioural symptoms that increased their risk of falls (but did not identify if from bed or other position) and therefore would require two half sized bed rails for bed mobility and transfers in and out of bed. The conclusion was made prior to spending one night in bed and before identifying whether the resident understood the use of bed rails and would whether they would pose any risks. The form did not include any notes made as to whether they were monitored for a period of time for bed safety risks related to their bed rails although the RN stated that, in general, residents were monitored for the first three nights after admission, for various behaviours, falls risk, toileting, wandering etc. If no issues were identified, no notes were made. A review of the resident's clinical record (progress notes) did not include any references to their bed safety status, but identified wandering in the evenings. The resident's plan of care identified that the resident was to have bed rails "put up according to need assessment: self reposition and transfer". This direction therefore put the onus on the PSW to decide with the resident if they would be used on a day to day basis. In the resident's clinical record it was identified the resident was prescribed medications and had sensory and cognitive impairments. In their progress notes, the resident was identified as being "confused" and was wandering, especially two months after admission. The RN, when interviewed on August 9, 2017, reported that the resident was independent with bed mobility and could get off the bed on their own, based on her own observations. Several PSWs who cared for the resident stated that they did not see the resident use their bed rails often, that the resident was independent with bed mobility and at times only needed some assistance to get off their bed. The PSWs stated that although the resident was confused at times, usually in the late evening, the resident was able to follow direction and communicate well with those PSWs who spoke their language. The RN stated she had no concerns for the resident related to bed entrapment but identified that the resident was not always able to follow direction and was more confused at night and was not able to participate in telling the RN if they wanted or needed the bed rails. According the guidance document, residents who are confused, have cognition impairment, not able to follow direction and have communication issues are at higher risk of bed related injuries and entrapment.

Several months after admission, the resident went to hospital for a health related issue and returned to the home four days later. A change in the resident's

condition was identified, and a re-admission assessment was completed on the same date. In this assessment, the resident was identified to require two upper split bed rails (even though the resident did not have split rails on their bed) for repositioning and bed mobility. Their status for bed mobility (ability to move independently in bed) decreased from needing supervision with the task upon admission to requiring extensive assistance. Their transfer status changed from needing supervision to limited assistance. Neither of these changes were reflected in their plan of care. PSWs reported that once the resident came back from hospital, they did not exit the bed independently and used their bed remote control more often to adjust their position in bed.

The RN stated that she asked the resident's SDM for permission to use the bed rails upon admission and they consented. No written record could be found that consent was acquired, the date consent was given and who provided it. According to the SDM and associated family members, permission to apply the bed rails was not discussed and no information about their associated risks was provided. The SDM identified that the resident did not use bed rails in the past and did not need them.

On a specified date in 2017, resident #100 passed away from an entrapment episode related to their bed rail. No witnesses were in the room during the incident. Interview with staff revealed that the resident was familiar with the controls of the bed and knew how to use their bed rails.

The Administrator stated that the resident's room was left undisturbed up until the completion of this inspection. Observations made at the time included the bed remote attached to the top rung of the right bed rail. Both of the two rotating assist bed rails, which were in the guard position, were very loose. The resident's bed was in the lowest position with a mat on the floor next to the bed. The bed system was tested or evaluated using an approved tool during the previous month, for entrapment zones. The bed passed all four zones of entrapment. None of the PSWs interviewed noticed that the bed rails were loose, and therefore in poor condition and therefore did not inform maintenance staff. In general, loose bed rails can increase the gap between a mattress and a bed rail. However, in this case, the bed rail was looser on the opposite end and the bed was articulated, which created different zones of entrapment that would not be identified during testing (which is done only with the bed in a flat position as per Health Canada Guidelines).

For this resident, several risk factors that were documented in the progress notes and in their admission assessment were not included in their BRNA. The resident had communication and cognitive issues, both increasing the risk of bed related injuries. No alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included hi/lo bed, a regular safety check and a call bell within easy reach. The resident was not re-evaluated for the use of their bed rails quarterly, as per the home's "Safe Use of Bedrails" policy, as only one BRNA form could be provided since their admission. No information was available in the licensee's policies regarding the use of bed accessories or attachments such as bed remote controls for residents that may have some cognitive deficits.

2. Resident #101 was observed resting in bed during the inspection, with a fixed small rail on their right and a quarter rail elevated on their left. Their written plan of care directed PSWs to "put left upper side rail and right upper assist rail up for repositioning" under the bed mobility focus of the plan dated January 2017, and "put one half rail and one assist rail at the head of bed while resident in bed to facilitate transfers" under the transfers focus of the plan dated February 2015. It appears that the resident had bed rails changed in February 2017, and the plan was not updated under both focuses. The terminology used to define the bed rails was also inconsistent between the bed rail manufacturer and the resident's plan of care.

The RN documented on the BRNA form that the resident had mobility issues or was unable to transfer safely to and from bed independently. The resident's plan of care identified that the resident required extensive physical assistance in bed by two staff members for bed mobility because the resident had specific physical limitations. The plan also identified that the resident had "physical limitations" and needed two persons physical assist in/or out of bed. Therefore, the resident was not able to independently use the bed rails to assist themselves either for bed mobility or to self-transfer in and out of bed. The resident's most current BRNA form was completed in late 2015, and no quarterly re-assessments were completed. The RN selected the upper left and upper right bed rails for repositioning and transfers. The BRNA form did not include a "fixed rail" option. The RN did not identify how the resident would benefit from the bed rails independently (whether the resident could use the bed rails without staff assistance), whether the bed rails posed any risks to the resident and whether any alternatives were trialled before the bed rails were applied.

For this resident, no alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included bed alarm, toileting schedule, a regular safety check and a call bell within easy reach.

3. Resident #102 was observed resting in bed during the inspection, with all four split rails elevated. The resident was admitted in mid 2017 and their BRNA form was not dated. The RN documented that the resident had communication issues and selected the split upper quarter bed rails for bed mobility and transfers. The resident's written plan of care directed PSWs to guide the resident's hands to the bed rails to help the resident push themselves up to stand. The plan included the need to "put bed rail(s) up according to needs assessment, upper left and upper right split". The resident was identified to have sensory impairments and was on a particular medication, both possible risk factors for bed related injury and entrapment. The BRNA form did not include some of the issues identified in the plan of care such sensory impairments. No documentation could be located in the resident's clinical record as to who gave consent for the use of the bed rails and on what date.

For this resident, no alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included a regular safety check and a call bell within easy reach.

4. Resident #104 was not observed in bed during the inspection, however their bed was observed to include two three quarter length bed rails, both padded. The bed rail was elevated on one side of the bed. The resident's BRNA form was completed in late 2016, and no quarterly re-assessments for bed rail use were completed since that time. The RN selected that both three quarter length bed rails would be applied for resident bed mobility, getting in and out of bed and for comfort and security. The RN included that the resident had a history of climbing over the bed rails, had a health condition or was on medications that could contribute to entrapment risk and had behavioral symptoms that may increase their risk of falls. The resident's written plan of care included that the resident required two staff to physically move the resident while in bed and required two staff members to transfer the resident out of bed using a mechanical lift and that staff were to "put two side rails (three quarter) up while in bed as per family request" and to "apply side rail pad on both side rails and head of bed to reduce chance of injury". A PSW stated that the resident was prone to sticking their feet and legs through the openings in the bed rail and that is why bed rail pads were added. They also identified that the resident did not use the bed rails and they were in place to keep

them from falling from bed. Other characteristics for the resident included that they had communication issues, were rarely understood, was restless and was severely cognitively impaired. Yet, despite these high risk factors for bed injury or entrapment and the fact that the resident was not able to use the bed rails, the RN concluded that bed rails would be applied. No documentation could be located in the resident's clinical record as to who gave consent for the use of the bed rails and on what date.

For this resident, no alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included falls prevention mattress, turning and repositioning schedule, toileting schedule, a regular safety check and a call bell within easy reach.

5. Resident #105 was not observed in bed at the time of inspection, however their bed was observed to include a blue thick bumper pad on the right quarter length bed rail which was elevated and an elevated left quarter length bed rail without a pad, which was seen on the night table. The PSW caring for this resident was asked if the resident used the bed rails at any time and they said no as the resident required total care. The PSW was asked why the pads were applied to the bed rails and she said that they were to prevent the resident from putting their hands and arms through the bed rail openings. The resident's BRNA form was last completed in mid 2016, and both quarter bed rails were selected for resident bed mobility and transfers. There was no information about the use of any accessory such as bumper pads and no identification that the resident was at risk of zone 1 or bed rail injury. No quarterly re-assessments for bed rail use were completed. The resident's written plan of care identified that the resident was cognitively impaired, had poor communication, required total dependence for bed mobility by two staff and needed the ceiling lift to transfer in and out of bed. Directions included "put two split bed rails up at the head of bed while in bed to facilitate repositioning and two bed bumper used while in bed to prevent injury" dated in early 2015. The information in the plan of care was inconsistent with the Bed Rail Needs Assessment. The resident clearly did not use the bed rails to assist in any way and was at high risk for bed related injury. No documentation could be located in the resident's clinical record as to who gave consent for the use of the bed rails and on what date.

For this resident, no alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included a regular safety check and a call bell within easy reach.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. [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:CO# 001

Issued on this 17 day of October 2017 (A1)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) : BERNADETTE SUSNIK (120) - (A1)

Inspection No. / No de l'inspection : 2017_539120_0048 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 018220-17 (A1)

Type of Inspection / Genre d'inspection: Critical Incident System

Report Date(s) / Date(s) du Rapport : Oct 17, 2017;(A1)

Licensee / Titulaire de permis : YEE HONG CENTRE FOR GERIATRIC CARE
2311 MCNICOLL AVENUE, SCARBOROUGH, ON, M1V-5L3

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2780 BUR OAK AVENUE, MARKHAM, ON, L6B-1C9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : AMY GO

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

To YEE HONG CENTRE FOR GERIATRIC CARE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing "Bed Rail Needs Assessment" form related to resident clinical assessments and the use of bed rails to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", (U.S. F.D.A, April 2003) which is recommended as the prevailing practice for individualized resident assessment of bed rails in the Health Canada guidance document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006". The amended form shall, at a minimum, include questions that can be answered by the assessor related to:

a. observing the resident while sleeping for a specified period of time, to establish their bed mobility habits, patterns of sleep, transfer abilities, behaviours and other relevant factors prior to the application of any bed rail (s) or bed system accessory (bed remote control) or alternative to bed rails

(bolster, positioning rolls, roll guards); and
b. observing the resident while sleeping for a specific period of time, to establish safety risks to the resident after a bed rail, accessory or alternative has been applied and deemed necessary; and
c. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during a specified observation period.

2. An interdisciplinary team shall assess all residents who use one or more bed rails using the amended bed safety assessment form and document the assessed results and recommendations for each resident. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006", and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", U.S. F.D.A, April 2003) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form.

4. Develop or acquire information fact sheets or pamphlets identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks/hazards of bed rail use, available alternatives to bed rails, how residents are assessed upon admission, how bed systems are evaluated for entrapment zones, the role of both the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails. The information shall be disseminated to relevant staff, families and residents (if resident is their own POA).

5. Amend the current "Safe Use of Bedrails" policy to include additional and relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", U.S. F.D.A, April 2003) and at a minimum the policy shall include;

a) details of the process of assessing residents upon admission and when a change in the resident's condition has been identified to monitor residents for risks associated with bed rail use and the use of any bed related attachments/accessories on an on-going basis; and
b) guidance for the assessors in being able to make clear decisions based on the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
c) alternatives that are available for the replacement of bed rails and the process of trialling the alternatives and documenting their use; and
d) how consent from the resident or Substitute Decision Maker (SDM) would be acquired and documented when one or bed rails have been consented to; and
e) what information will be shared with the SDM or resident prior to the application of the bed rails; and
f) what interventions are available to mitigate any identified bed safety entrapment or injury risks should a resident benefit more from the use of one or more bed rail(s)(i.e. wedges, bolsters, bed rail pads) vs the risk; and
g) the role of the SDM and resident in selecting the appropriate device for bed mobility and transfers; and
h) additional information on the role and responsibilities of the personal support worker who is involved in observing residents for risks related to the use of one or more bed rails.

6. Provide face to face training to all relevant staff (PSWs, registered staff, housekeeping, maintenance, OT/PT) who are affiliated with residents and/or their bed systems with respect to the home's amended bed safety policies and procedures, bed system zones of entrapment, resident clinical assessment overview, specific staff roles and responsibilities, how to determine if bed systems are in good working order, how to determine if a resident is at risk of entrapment, strangulation, injury or entanglement while in their bed system and the course of action to be taken when risks or poor maintenance are identified.

Grounds / Motifs :

1. The licensee did not ensure that, where bed rails were used, that residents were

assessed in accordance with prevailing practices to minimize risk to the residents.

According to prevailing practices titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada), residents are to be clinically assessed by an interdisciplinary team, over a period of time, while in bed, by answering a series of questions to determine why bed rails would be needed (either as a restraint or a device to assist with bed mobility and transfers) and if bed rails are a safe option for their use. Bed rails are classified as medical devices by Health Canada and come with inherent risks or hazards that can be fatal to residents. Hazards include but are not limited to suspension, entrapment, skin injuries and entanglement. As such, bed rails must be maintained in a safe condition (as per manufacturer's directions), pass all zones of entrapment (specific areas that are measured around the bed rail and mattress and the bed rail itself), and the resident must be clinically assessed to determine if they are able to understand and safely use the bed rails to minimize any inherent risks to themselves. The assessment guideline offers examples of key assessment questions that guides decision-making such as the resident's history of falls from bed, previous bed rail use, communication limitations, their mobility, cognition status, involuntary body movements, their physical size, pain, the resident's medical status, behaviours, medication use, toileting habits, sleeping patterns, environmental factors and the entrapment status of the resident's bed.

The assessment guideline also emphasizes the need to document clearly whether alternatives to bed rails were used (soft rails or bolsters, perimeter reminders, reaching pole) and if they were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. The final conclusion, with input from either the resident or their SDM (Substitute Decision Maker) and other interdisciplinary team members, would be made about the necessity and safety of bed rail use for a particular resident and the details documented on a form (electronically or on paper). The details would include why one or more bed rails were required, the resident's overall risk for injury, suspension or entrapment, permission or consent (from either the SDM or resident), the size or type of rail to be applied (rotating assist rail, fixed assist rail, 1/4, 1/2 or 3/4 bed rail), when the rails are to be applied (at night only, when requested by resident or with staff assistance), how many bed rails (one, two or four), on what sides of the bed and whether any accessory or amendment to the bed system is necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's clinical assessment process of residents using bed rails was compared to the assessment guidelines and determined to lack several key components and was therefore not developed in accordance with prevailing practices as identified in the above assessment guideline.

A) The licensee's two policies related to bed safety were reviewed and included "Bed Safety" dated April 2016, and "Safe Use of Bedrails" dated May 2016. No reference was made to the above noted guideline in either policy, however a reference was made to Health Canada's guideline titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2008", which references the above noted FDA clinical guidance document. According to the Director of Resident Care, the guideline was not reviewed by himself or the registered nurses (RN) in the home and therefore not fully incorporated into their clinical practices.

As part of their process in assessing the resident, the RNs were directed by their "Safe Use of Bedrails" policy to use a form titled "Bed Rail Need Assessment" (BRNA) and the procedures included the need to “evaluate the resident’s use of bed rails quarterly” and to “assess the resident’s safety in bed”. No specific information was included to define how the resident’s safety while in bed was to be completed. The procedures did not include how long the resident would be observed while in bed (with and without bed rails), the length of time resident’s would be monitored with or without bed rails, what alternatives need to be trialled before deciding that bed rails are an ideal option and for how long, who would monitor the resident during the night and how often, what specific hazards would be monitored for and subsequently documented and how specifically other team members would participate in assisting the RN in making a final decision about the benefits versus the risks of the resident's bed rail.

The licensee’s policy titled “Bed Safety” was geared towards ensuring that the residents’ beds were in good condition, passed all zones of entrapment and were inspected on a regular basis. It included the role of the RN/RPN to “monitor resident risks of bed entrapment” and “educate residents and their families about the proper use of bed and side rails” and “be aware of malfunctioning bed components”. The policy did not identify how consent would be acquired from the resident or SDM to apply the bed rails and did not identify exactly what information needed to be shared with the SDM or resident with respect to bed rail hazards. No written information regarding the hazards of bed rails was made available to any family member or

resident.

B) The BRNA form, which was required to be used upon admission (or with any change in status), was not designed to document what bed related risks were monitored for after admission. Part A was to be completed upon admission by answering questions that the RN would not have been independently aware of (unless the form was used with a change in status after admission). The questions included the resident's risk of entrapment, involuntary body movements, body size, communication level, behaviours increasing risk of falling, behaviours increasing risk for bed entrapment, history of bed entrapment and history of climbing over the bed rails. These questions, when answered were completed with the resident's SDM, before the resident spent one night in bed after admission, as identified with resident #100 below. The form did not include a section that included information gathered by an interdisciplinary team of staff who were tasked at monitoring the resident in bed, over a period of time, with and without the bed rails. Examples of questions to assist decision making around the hazards of bed rail use include but are not limited to bed rail injuries (banging into or against the rail), sleeping habits (if the resident was restless, frequently exited the bed, was in pain, had a sleep disorder, hallucinations, delirium, slept next to a rail, or along edge of bed), if body parts went through the rail, if the resident understood the purpose of the bed rail or knew how to apply it independently, if the resident knew how to use other bed related components such as a bed remote and their bed mobility and transfer capabilities.

The BRNA form included an alternatives section for completion by the RN, however the options on the form included interventions such as bed alarm, fall prevention mat, hi low bed and toileting, turning and repositioning schedules. The interventions are typically applied with or without bed rails in place. No bed rail alternatives were listed such as perimeter reminders, positioning rolls, roll guards, defined perimeter mattress covers or soft rails/bolsters.

C) According to the RN who completed the assessments using the BRNA form, an interdisciplinary team approach was taken by including the Occupational Therapist (OT) and Personal Support Workers (PSW) in providing information about the resident. The OT reported having a role in assessing the resident's transfer capabilities (in and out of bed) and their general mobility status and the PSWs provided information about the residents' abilities to reposition themselves in bed and their overall activities of daily living (sleeping, eating, dressing, toileting, pain, falls, communication etc.). The staff roles identified and to what extent their input would

assist the RN in making decisions about the residents' overall bed safety risks was not included in either of the bed related safety policies. Progress notes were made when the residents were first admitted and a standard "safety check" completed. The safety checks were described as being a basic check, to determine if the resident was in bed, sleeping or awake, and not in any distress. Safety checks are a continuous routine of all staff for all residents, however bed safety hazards are not specifically included with these checks. The bed safety policies did not include specifically what type of bed safety risks or hazards the interdisciplinary team should be monitoring.

D) During the tour of the home in two specific home areas, observations were made that approximately 99 percent of resident beds had at least one bed rail applied, either a quarter length bed rail raised or a rotating assist rail in the guard position (centre of bed). In one home area, the residents were all considered to have cognitive impairment. A random selection of residents were chosen for review, some who were observed in bed at the time of inspection. Although not all of these residents occupied their beds at the time of the observation, the residents all had a plan of care identifying that PSWs were to apply them. According to the RN who completed their assessments, none were identified to have bed rails that were considered a restraint or that had any limiting or inhibiting effects for the resident. To confirm the need for bed rails to be engaged or "raised" while residents were out of bed, the residents' written plans of care were reviewed.

1. Resident #100 was admitted to the home on a specified date in 2017, and had a bed safety assessment completed on the same date. The RN documented on the BRNA that the resident's sole risk factor for bed safety was their behavioural symptoms that increased their risk of falls (but did not identify if from bed or other position) and therefore would require two half sized bed rails for bed mobility and transfers in and out of bed. The conclusion was made prior to spending one night in bed and before identifying whether the resident understood the use of bed rails and would whether they would pose any risks. The form did not include any notes made as to whether they were monitored for a period of time for bed safety risks related to their bed rails although the RN stated that, in general, residents were monitored for the first three nights after admission, for various behaviours, falls risk, toileting, wandering etc. If no issues were identified, no notes were made. A review of the resident's clinical record (progress notes) did not include any references to their bed safety status, but identified wandering in the evenings. The resident's plan of care

identified that the resident was to have bed rails "put up according to need assessment: self reposition and transfer". This direction therefore put the onus on the PSW to decide with the resident if they would be used on a day to day basis. In the resident's clinical record it was identified the resident was prescribed medications and had sensory and cognitive impairments. In their progress notes, the resident was identified as being "confused" and was wandering, especially two months after admission. The RN, when interviewed on August 9, 2017, reported that the resident was independent with bed mobility and could get off the bed on their own, based on her own observations. Several PSWs who cared for the resident stated that they did not see the resident use their bed rails often, that the resident was independent with bed mobility and at times only needed some assistance to get off their bed. The PSWs stated that although the resident was confused at times, usually in the late evening, the resident was able to follow direction and communicate well with those PSWs who spoke their language. The RN stated she had no concerns for the resident related to bed entrapment but identified that the resident was not always able to follow direction and was more confused at night and was not able to participate in telling the RN if they wanted or needed the bed rails. According the guidance document, residents who are confused, have cognition impairment, not able to follow direction and have communication issues are at higher risk of bed related injuries and entrapment.

Several months after admission, the resident went to hospital for a health related issue and returned to the home four days later. A change in the resident's condition was identified, and a re-admission assessment was completed on the same date. In this assessment, the resident was identified to require two upper split bed rails (even though the resident did not have split rails on their bed) for repositioning and bed mobility. Their status for bed mobility (ability to move independently in bed) decreased from needing supervision with the task upon admission to requiring extensive assistance. Their transfer status changed from needing supervision to limited assistance. Neither of these changes were reflected in their plan of care. PSWs reported that once the resident came back from hospital, they did not exit the bed independently and used their bed remote control more often to adjust their position in bed.

The RN stated that she asked the resident's SDM for permission to use the bed rails upon admission and they consented. No written record could be found that consent was acquired, the date consent was given and who provided it. According to the SDM and associated family members, permission to apply the bed rails was not

discussed and no information about their associated risks was provided. The SDM identified that the resident did not use bed rails in the past and did not need them.

On a specified date in 2017, resident #100 passed away from an entrapment episode related to their bed rail. No witnesses were in the room during the incident. Interview with staff revealed that the resident was familiar with the controls of the bed and knew how to use their bed rails.

The Administrator stated that the resident's room was left undisturbed up until the completion of this inspection. Observations made at the time included the bed remote attached to the top rung of the right bed rail. Both of the two rotating assist bed rails, which were in the guard position, were very loose. The resident's bed was in the lowest position with a mat on the floor next to the bed. The bed system was tested or evaluated using an approved tool during the previous month, for entrapment zones. The bed passed all four zones of entrapment. None of the PSWs interviewed noticed that the bed rails were loose, and therefore in poor condition and therefore did not inform maintenance staff. In general, loose bed rails can increase the gap between a mattress and a bed rail. However, in this case, the bed rail was looser on the opposite end and the bed was articulated, which created different zones of entrapment that would not be identified during testing (which is done only with the bed in a flat position as per Health Canada Guidelines).

For this resident, several risk factors that were documented in the progress notes and in their admission assessment were not included in their BRNA. The resident had communication and cognitive issues, both increasing the risk of bed related injuries. No alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included hi/lo bed, a regular safety check and a call bell within easy reach. The resident was not re-evaluated for the use of their bed rails quarterly, as per the home's "Safe Use of Bedrails" policy, as only one BRNA form could be provided since their admission. No information was available in the licensee's policies regarding the use of bed accessories or attachments such as bed remote controls for residents that may have some cognitive deficits.

2. Resident #101 was observed resting in bed during the inspection, with a fixed small rail on their right and a quarter rail elevated on their left. Their written plan of care directed PSWs to "put left upper side rail and right upper assist rail up for repositioning" under the bed mobility focus of the plan dated January 2017, and "put one half rail and one assist rail at the head of bed while resident in bed to facilitate

transfers" under the transfers focus of the plan dated February 2015. It appears that the resident had bed rails changed in February 2017, and the plan was not updated under both focuses. The terminology used to define the bed rails was also inconsistent between the bed rail manufacturer and the resident's plan of care.

The RN documented on the BRNA form that the resident had mobility issues or was unable to transfer safely to and from bed independently. The resident's plan of care identified that the resident required extensive physical assistance in bed by two staff members for bed mobility because the resident had specific physical limitations. The plan also identified that the resident had "physical limitations" and needed two persons physical assist in/or out of bed. Therefore, the resident was not able to independently use the bed rails to assist themselves either for bed mobility or to self-transfer in and out of bed. The resident's most current BRNA form was completed in late 2015, and no quarterly re-assessments were completed. The RN selected the upper left and upper right bed rails for repositioning and transfers. The BRNA form did not include a "fixed rail" option. The RN did not identify how the resident would benefit from the bed rails independently (whether the resident could use the bed rails without staff assistance), whether the bed rails posed any risks to the resident and whether any alternatives were trialled before the bed rails were applied.

For this resident, no alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included bed alarm, toileting schedule, a regular safety check and a call bell within easy reach.

3. Resident #102 was observed resting in bed during the inspection, with all four split rails elevated. The resident was admitted in mid 2017 and their BRNA form was not dated. The RN documented that the resident had communication issues and selected the split upper quarter bed rails for bed mobility and transfers. The resident's written plan of care directed PSWs to guide the resident's hands to the bed rails to help the resident push themselves up to stand. The plan included the need to "put bed rail(s) up according to needs assessment, upper left and upper right split". The resident was identified to have sensory impairments and was on a particular medication, both possible risk factors for bed related injury and entrapment. The BRNA form did not include some of the issues identified in the plan of care such sensory impairments. No documentation could be located in the resident's clinical record as to who gave consent for the use of the bed rails and on what date.

For this resident, no alternatives were documented as trialled before applying the

bed rails. Interventions listed on the BRNA form included a regular safety check and a call bell within easy reach.

4. Resident #104 was not observed in bed during the inspection, however their bed was observed to include two three quarter length bed rails, both padded. The bed rail was elevated on one side of the bed. The resident's BRNA form was completed in late 2016, and no quarterly re-assessments for bed rail use were completed since that time. The RN selected that both three quarter length bed rails would be applied for resident bed mobility, getting in and out of bed and for comfort and security. The RN included that the resident had a history of climbing over the bed rails, had a health condition or was on medications that could contribute to entrapment risk and had behavioral symptoms that may increase their risk of falls. The resident's written plan of care included that the resident required two staff to physically move the resident while in bed and required two staff members to transfer the resident out of bed using a mechanical lift and that staff were to "put two side rails (three quarter) up while in bed as per family request" and to "apply side rail pad on both side rails and head of bed to reduce chance of injury". A PSW stated that the resident was prone to sticking their feet and legs through the openings in the bed rail and that is why bed rail pads were added. They also identified that the resident did not use the bed rails and they were in place to keep them from falling from bed. Other characteristics for the resident included that they had communication issues, were rarely understood, was restless and was severely cognitively impaired. Yet, despite these high risk factors for bed injury or entrapment and the fact that the resident was not able to use the bed rails, the RN concluded that bed rails would be applied. No documentation could be located in the resident's clinical record as to who gave consent for the use of the bed rails and on what date.

For this resident, no alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included falls prevention mattress, turning and repositioning schedule, toileting schedule, a regular safety check and a call bell within easy reach.

5. Resident #105 was not observed in bed at the time of inspection, however their bed was observed to include a blue thick bumper pad on the right quarter length bed rail which was elevated and an elevated left quarter length bed rail without a pad, which was seen on the night table. The PSW caring for this resident was asked if the resident used the bed rails at any time and they said no as the resident required total care. The PSW was asked why the pads were applied to the bed rails and she said

that they were to prevent the resident from putting their hands and arms through the bed rail openings. The resident's BRNA form was last completed in mid 2016, and both quarter bed rails were selected for resident bed mobility and transfers. There was no information about the use of any accessory such as bumper pads and no identification that the resident was at risk of zone 1 or bed rail injury. No quarterly re-assessments for bed rail use were completed. The resident's written plan of care identified that the resident was cognitively impaired, had poor communication, required total dependence for bed mobility by two staff and needed the ceiling lift to transfer in and out of bed. Directions included "put two split bed rails up at the head of bed while in bed to facilitate repositioning and two bed bumper used while in bed to prevent injury" dated in early 2015. The information in the plan of care was inconsistent with the Bed Rail Needs Assessment. The resident clearly did not use the bed rails to assist in any way and was at high risk for bed related injury. No documentation could be located in the resident's clinical record as to who gave consent for the use of the bed rails and on what date.

For this resident, no alternatives were documented as trialled before applying the bed rails. Interventions listed on the BRNA form included a regular safety check and a call bell within easy reach.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 3 (actual harm for one resident), the scope is 3 (the number of residents who have not been adequately assessed is widespread) and the compliance history is 2 (previous non-compliance issued that is unrelated). (120)

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

Mar 31, 2018(A1)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS 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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 17 day of October 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : BERNADETTE SUSNIK

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Service Area Office / Bureau régional de services : Toronto