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
Feb 06, 2018;	2017_625133_0018 (A1)	007728-17	Follow up

Licensee/Titulaire de permis

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road OTTAWA ON K1G 5Z6

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

THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD OTTAWA ON K1G 5Z6

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

JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance date for Compliance Order (CO) #001 has been extended from March 12, 2018 to June 29, 2018. The CO was issued pursuant to Ontario Regulation 79/10, s. 15 (1), in relation to the use bed rails. In support of this request, the licensee submitted an action plan to the MOHLTC, which includes the purchase of 160 new bed systems that are expected to be delivered for mid March 2018. The action plan outlines steps that are being taken to mitigate the potential risk of resident entrapment in relation to specified bed systems.

Issued on this 6 day of February 2018 (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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JESSICA LAPENSEE (133) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): November 7, 8, 9, 10, 14, 2017

This inspection was in follow up to Compliance Order #001, issued to the licensee on April 13, 2017 as a result of Resident Quality Inspection #2017_627138_0009. The Compliance Order is reissued as a result of this inspection.

During the course of the inspection, the inspector(s) spoke with the Chief Operating Officer, the Director of Nursing, the Director of Support Services, the Manager of Support Services, a Physiotherapist, an Occupational Therapist, Registered Nurses, Registered Practical Nurses, Personal Support Workers, and residents.

The Inspector observed resident bed systems, reviewed resident health care records, reviewed the "bed entrapment risk assessment - V5" tool, reviewed the "Bed Entrapment Program" policy and procedure with issue date June 28, 2017, reviewed Surge Learning slide deck title "Bed Program - Bed Entrapment Assessment Tool", reviewed a summary document related to therapeutic surfaces in use in the home, reviewed PSW meeting minutes for July 2017, reviewed information related to the Joerns bed systems in use in the home.

The following Inspection Protocols were used during this inspection:

Safe and Secure Home

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

2 WN(s)
1 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 has failed to ensure that, where bed rails are used, 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.

On April 13, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_627138_0009. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by July 07, 2017.

Parts 1 and 2 of the compliance order were related to residents' bed systems and parts 3 to 8 of the compliance order were related to the assessment of residents. The parts of the compliance order that have not been complied with will be referenced and addressed below.

Part 1 and part 2 of the compliance order required the licensee to take the following actions:

1. Re-evaluate all bed systems where bed rails are used in the home, in accordance with evidence-based practices. All reassessment are to be documented.

2. Establish and implement a process for ensuring that any bed system failures are addressed immediately by taking the necessary corrective actions. All actions taken to address bed system failures are to be documented.

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

Related to part 1 of the compliance order:

On November 7, 2017, in discussion with the Chief Operating Officer (COO), the Director of Nursing (DON), and Registered Nurse (RN) #101, it was established that entrapment zones 1-4 on all resident bed systems had not been evaluated in accordance with the tests described in the HC guidance document. RN #101, identified as the lead for the bed entrapment team, explained that in response to part one of the compliance order, all residents' bed systems had been observed with a focus on addressing zone 7 gaps. As well, RN #101 indicated that zone 6 was observed and zone 3 was measured with a tape measure. RN #101 explained that the overall focus was in ensuring a proper fit between the mattress and the bed frame, and ensuring that measures were in place to prevent mattresses from sliding. It was confirmed that evaluating entrapment zones 1-4 in accordance with the tests described in the HC guidance document had not been a consideration.

Related to part 2 of the compliance order:

On November 7, 2017, in discussion with the Chief Operating Officer (COO), the Director of Nursing (DON), and RN #101, RN#101 explained that a bed system failure was understood to be related to a mattress that did not fit the bed frame, or to a mattress that was not prevented from sliding. It was confirmed that

entrapment zone 1-4 failures had not been a consideration, as the prescribed testing process did not occur as per the HC guidance document. The Inspector was informed that mattresses were changed as required, and solutions to prevent mattresses from sliding were implemented.

Related to the assessment of residents where bed rails are used:

As previously referenced, all LTC homes have been directed to use the HC guidance document as a best practice document. The HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered and are specified. The process is to result in a documented risk benefit assessment, prior to the team's conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:

a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.

b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.

c) Comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident.

The 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed

rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Part 3 of the compliance order required the licensee to take the following action:

3. Develop and implement a documented multidisciplinary team assessment process for all residents with one or more bed rails in use (including partial rails), and for all residents for which the use of one or more bed rails are being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003)". As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

With regards to a documented team assessment process:

On November 7, 2017, during a discussion with the Director of Nursing (DON) and RN #101, the Inspector was provided with a copy of the home's new assessment tool titled "Bed Entrapment Risk Assessment – V5" which was to be completed by registered nursing staff. It was noted that the assessment form did not include a section to document the names of the team members that participated in the assessment. RN #101 indicated that when all residents' were assessed in response to the compliance order, it was expected that registered staff spoke with Personal Support Workers (PSWs) about the resident when completing the assessment. For new residents, RN #101 indicated that the assessment would be done within 24 hours of admission and that registered nursing staff would be expected to speak with the PSWs. The DON indicated that all new residents are assessed by the Physiotherapy department for transfer status, and this could also be a source of information for the registered staff when completing the assessment as well.

On November 8, 2017, the Inspector observed resident #001 in his/her bed with two bed rails in the up position. The Inspector subsequently interviewed Registered Nurse (RN) # 102 about her assessment of resident #001, related to bed rail use, upon his/her admission to the home in 2017. The RN indicated that no

other staff members were involved in the assessment process.

On November 9, 2017, the Inspector observed resident #003's bed system and it was noted that there were two bed rails in the up position. The Inspector subsequently interviewed RN #103 about her assessment of resident #003, related to bed rail use, following his/her admission to the home in 2017. The RN indicated that no other staff members were involved in the assessment process.

Further related to resident #003, on November 9, 2017, RN #103 confirmed that she had completed the "Bed Entrapment Risk Assessment – V5" tool for the resident twelve days following his/her admission to the home. RN #103 confirmed that despite this, bed rails were in use for resident #003 as of the day the resident was admitted to the home. On November 14, 2017, PSW #109 confirmed that bed rails had been in use for resident #003 since the day the resident was admitted to the home. As per the 2003 FDA Clinical Guidance document, a team assessment process, as prescribed, is to occur prior to the implementation of bed rail use for a resident.

On November 10, 2017, the Inspector observed resident #005's bed system and it was noted that there were two bed rails in the up position. The Inspector subsequently interviewed RN #104 about her assessment of resident #005, related to bed rail use, following his/her admission to the home in 2017. The RN indicated that no other staff members were involved in the assessment process.

With regards to the resident assessment and inclusion of all factors, elements and conditions as outlined in the 2003 FDA Clinical Guidance document:

On November 7, 2017, upon review of the "Bed Entrapment Risk Assessment V5" form with the DON and RN #101, it was noted that all of the factors to be included in the individual resident assessment, as per the 2003 FDA Clinical Guidance document, were not captured. For example, there were no questions related to sleep habits, medication, and ability to toilet self safely. The DON and RN #101 indicated that medication and ability to toilet self safely were factors that had not been incorporated into the assessment process. Related to sleep habits, RN #101 indicated that it was expected that registered nursing staff would know to consider this factor when completing an assessment. RN #101 indicated that there was a need to specifically include sleep habits into the assessment tool to ensure it was captured.

On November 10, 2017, RN#104 and the Inspector reviewed all of the factors to be considered as outlined in the 2003 FDA Clinical Guidance document. RN#104 indicated that sleep habits and medications were two factors that she would not have considered when completing resident #005's initial assessment related to bed rail use, nor would she have considered these factors for other residents she had assessed.

Part 4 of the compliance order required the licensee to take the following action:

4. Ensure that the multidisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternative to bed rail use, and that the interventions or changes are trialed if appropriate and dependent on the resident's assessment, during a specified observation period prior to the application of any bed rails or prior to the removal from use of any bed rails.

On November 7, 2017, RN #101 indicated that the resident assessment process implemented with regards to bed rail use does not result in the consideration of alternatives to bed rail use or the trialing of alternatives to bed rail use, if appropriate, prior to the application of bed rails.

On November 9, 2017, RN #103 and the Inspector discussed the RN's assessment of resident #003 following his/her admission to the home in 2017. RN #103 indicated that there had been no consideration of alternatives to bed rail use for resident #003.

On November 10, 2017, RN #104 and the Inspector discussed the RN's assessment of resident #005 following his/her admission to the home in 2017. RN #104 indicated that there had been no consideration of alternatives to bed rail use for resident #005. RN #104 indicated that the assessment process does not lead to the consideration of alternatives to bed rail use.

Part 6 of the compliance order required the licensee to take the following action:

6. Ensure that the multidisciplinary team clearly documents the final results of the assessment/reassessment, including the risk-benefit analysis and ensuing recommendation.

On November 7, 2017, the DON and RN #101 indicated that the assessment

process implemented with regards to bed rail use does not result in a team clearly documenting the final results of the assessment/reassessment, including the risk benefit analysis and the ensuing recommendations.

Related to the notion of a documented assessment including a risk benefit analysis, the Inspector found that for two residents with bed rails in use at the time of the inspection, there was no documented assessment within the resident's health care record. The Inspector did locate reference to the use of bed rails for both residents within an admission note, made by RN #102, on the residents' respective admission dates.

On November 9, 2017, the Inspector observed resident #002's bed system and it was noted that there were two bed rails in the up position. On November 10, 2017, the Inspector observed resident #004's bed system and it was noted that there were two bed rails in the up position.

On November 10, 2017, the Inspector interviewed RN #102 about her implementation of bed rail use for resident #002 and #004. The RN indicated that on the residents' respective admission days, she would have developed a general understanding of the potential risks and benefits related to bed rail use for the respective residents, based on observation and discussion with the residents and the family. The RN indicated she would have discussed those potential risks and benefits with the family during the admission process, and then the family would have informed the RN if bed rails were to be used. The RN indicated she could not recall specific details related to either resident, however, upon review of the admission notes, the RN confirmed that bed rails had been put into use for both residents on their respective admission dates. The RN confirmed that she did not complete the "Bed Entrapment Risk Assessment" tool for resident #002 and #004. As per the 2003 FDA Clinical Guidance document, a team assessment process, as prescribed, is to occur prior to the implementation of bed rail use for a resident.

Related to the notion of documented recommendations:

On November 8, 9 and 14, 2017, RN #102, RN #103 and RN #104, respectively, informed the Inspector that they do not make recommendations related to bed rail use. The RN's indicated that they discuss the risks and benefits of bed rail use with the resident and or the resident's family, and then the resident or the resident's family decides if bed rails are to be used.

Part 7 of the compliance order required the licensee to take the following action:

7. Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team. Include all required information as specified in the FDA 2003 clinical guidance document, such as related to the use of bed rails for a medical symptom or condition vs. bed rails used for a resident's mobility and/or transferring.

The Inspector first observed that bed rails were in use for resident #001 on November 8, 2017. Resident #001's health care record was reviewed on November 8, 2017 and again on November 14, 2017. The written care plan, the care plan kardex and the MDS kardex for resident #001 did not include reference to the use of bed rails.

The Inspector first observed that bed rails were in use for resident #002 on November 9, 2017. Resident #002's health care record was reviewed on November 9, 2017 and again on November 14, 2017. The written care plan and associated kardex for resident #002 did not include reference to the use of bed rails. The MDS kardex reflected that bed rails were in use for bed mobility or transfer.

The Inspector first observed that bed rails were in use for resident #004 on November 10, 2017. Resident #004's health care record was reviewed on November 9, 2017 and again on November 14, 2017. The written care plan and associated kardex for resident #004 did not include reference to the use of bed rails. The MDS kardex reflected that bed rails were in use for bed mobility or transfer.

On November 14, 2017, Personal Support Worker Supervisor #105 (PSWS) indicated that Personal Support Workers (PSW) have access to residents' written care plans, which are printed and placed in a binder at the nurses' stations, and to the associated care plan kardex on laptops or through the Point of Care terminals. PSWS #105 indicated that the MDS kardex is not printed off for the PSWs to review and PSWs are not expected to consult the MDS kardex.

Further related to resident #001, on November 14, 2017, the Inspector asked PSW #108 about the resident's use of bed rails. PSW #108 reviewed the resident's care plan kardex on a Point of Care terminal and indicated that there was no reference to bed rail use for the resident. PSW #108 indicated that this was her main source

for information. PSW #108 then reviewed resident #001's printed care plan in a binder at the nurses' station and indicated that there was no reference to bed rail use for the resident. PSW #108 indicated that she was told last week that it was safer to have bed rails in use for resident #001. PSW #108 indicated that the two bed rails are up at all times for resident #001.

Further related to resident #002, on November 9, 2017, PSW #106 indicated to the Inspector that the resident does not use bed rails for bed mobility or transfers, as was indicated in the MDS kardex. PSW #106 indicated that the resident is a very nervous and anxious person and that the resident always holds on to the left bed rail when sleeping.

Further related to resident #004, on November 14, 2017, PSW #107 indicated to the Inspector that the resident does not use bed rails for bed mobility or transfers, as was indicated in the MDS kardex. PSW #107 indicated that she assumed that the bed rails were in use for resident #004 for overall safety, as the resident does not use the bed rails. PSW #107 reviewed the resident #004's care plan and the associated care plan kardex and noted that the use of bed rails was not referenced. PSW #107 indicated that she assumed that registered nursing staff had forgotten to include use of bed rails in the resident's care plan, as bed rails had been in use for the resident since the resident's admission to the home.

In summary, the licensee has failed to comply with all aspects of Compliance Order #001, issued as a result of Resident Quality Inspection #2017_627138_0009. As a result of the continuing widespread non-compliance, which presents the potential for actual harm, a subsequent Compliance Order will be served to the licensee. [s. 15. (1) (a)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the procedures that have been developed and implemented serve to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment.

The following finding of non-compliance is specifically related to the repair of specified bed rails.

On November 9, 2017, the Inspector observed resident #006's bed system. Both Bertec bed rails were up and latched in position. Both rails were loose, with the left rail notably looser that the right. The rails could be moved up and down, back and forth towards the head of the bed and the foot of the bed, and towards the mattress and away from the mattress.

On November 9, 2017, the Inspector observed resident #003's bed system. Both Bertec bed rails were up and latched in position. Both rails were loose, with the right rail notably looser than the left rail. The degree of play observed was as described above, for resident #006's bed rails.

On November 9, 2017, the Inspector observed resident #002's bed system. Both

Bertec bed rails were up and latched in position. Both rails were loose, with a degree of play as described above for resident #006's bed rails and for resident #003's bed rails.

On November 10, 2017, the Inspector observed resident #004's bed system. Both Stryker bed rails were up and latched in position. The left rail was very loose and moved easily back and forth between the head of the bed and the foot of the bed, towards the mattress and away from the mattress.

On November 10, 2017, the Manager of Support Services accompanied the Inspector to resident #002's bedroom to observe the Bertec bed rails in use for the resident. The MSS manipulated the left bed rail and indicated that it was loose. The MSS indicated that the bushings were very worn and this resulted in the extra play. The MSS manipulated the right bed rail and indicated that it was the same as the left bed rail.

On November 10, 2017, the MSS accompanied the Inspector to resident #006's bedroom to observe the Bertec bed rails in use for the resident. The MSS manipulated the bed rails and indicated that both were loose, with the left rail notably looser than the right rail. As well, it was noted by the MSS that the headboard was also very loose, moving easily back and forth with minimal pressure applied.

On November 10, 2017, the MSS accompanied the Inspector to resident #007's bedroom to observe the Joerns bed rails in use for the resident. Both bed rails were up and latched in position. The MSS manipulated the right rail and noted that it was loose. It was observed that the degree of play allowed the rail to move towards and away from the mattress. The MSS noted that there were two screws at the base of the rail which could be tightened.

On November 10, 2017, the MSS accompanied the Inspector to resident #003's bedroom to observe the Bertec bed rails in use for the resident. The MSS manipulated the bed rails and noted that both were loose, with the right rail notably looser than the left rail.

On November 14, 2017, the MSS accompanied the Inspector to resident #004's bedroom to observe the Stryker bed rails in use for the resident. The MSS indicated that the left rail was loose and that this was likely due to the bushings. The SSM indicated that due to the age of the bed system, he was unsure if the

rails could be tightened to a point where there was no play.

The MSS indicated to the Inspector that bed rails are inspected when a room is vacated, and, bed rails are inspected annually. The MSS indicated he would follow up with maintenance staff and have the identified bed rails tightened as much as possible. The SSM indicated that all bed rails would be inspected in conjunction with the home wide bed system evaluation process that would be conducted in response to the non-compliance described in Written Notification #1 within this inspection report.

Although procedures has been developed and implemented, the procedures do not ensure that bed rails are maintained in good repair. [s. 90. (2) (b)]

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 with the requirement that procedures be developed and implemented to ensure that bed rails are kept in good repair, to be implemented voluntarily.

Issued on this 6 day of February 2018 (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) : JESSICA LAPENSEE (133) - (A1)

Inspection No. / No de l’inspection : 2017_625133_0018 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 007728-17 (A1)

Type of Inspection / Genre d’inspection: Follow up

Report Date(s) / Date(s) du Rapport : Feb 06, 2018;(A1)

Licensee / Titulaire de permis : THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 Russell Road, OTTAWA, ON, K1G-5Z6

LTC Home / Foyer de SLD : THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE
1750 RUSSELL ROAD, OTTAWA, ON, K1G-5Z6

Name of Administrator / Nom de l’administratrice ou de l’administrateur : Akos Hoffer

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

To THE PERLEY AND RIDEAU VETERANS' HEALTH CENTRE, 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)

Linked to Existing Order / Lien vers ordre existant: 2017_627138_0009, 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 :

1. Evaluate all bed systems where bed rails are used in the home, in accordance with the Health Canada evidence-based practice document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". Ensure that bed rails with intermediate positions, such as the Stryker bed rails, are tested at every intermediate position. All bed system evaluations are to be documented.

2. Establish and implement a process for ensuring that any bed system failures are addressed immediately by taking the necessary corrective actions. Consider the direction provided in the 2006 FDA prevailing practices document titled "A Guide for Modifying Bed System and Using Accessories to Reduce the Risk of Entrapment". All actions taken to address bed system failures are to be documented.

3. Take immediate and documented steps to prevent entrapment, taking into consideration all potential zones of entrapment, should it be unavoidable that a resident remain in a bed system that does not pass the prescribed entrapment zone testing, for any period of time, while the bed system failure is being addressed as per part #2 of this compliance order. Consider the direction provided in the 2006 FDA prevailing practices document titled "A Guide for Modifying Bed System and Using Accessories to Reduce the Risk of Entrapment". This also pertains to the use of pressure reduction therapeutic products which cannot pass the entrapment zone testing as prescribed by Health Canada by function of their design. In such cases, the therapeutic benefit should outweigh the risk of entrapment presented by use of such a system. The risk benefit analysis specific to the use of such therapeutic products is to be documented, and steps to prevent entrapment, taking into consideration all potential zones of entrapment, are to be in place.

4. Create and maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident and which reflects the most recent evaluation for each bed system. Re-evaluate bed systems as required, such as when a new bed system is created as a result of a change or replacement of components, and when there is reason to believe some components are worn (eg. Rails wobble or are damaged, mattresses are softer)

5. Develop and implement a documented interdisciplinary team assessment process for all residents with one or more bed rails in use and for all residents for which the use of one or more bed rails are being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the prevailing practices document Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003). As well, the process shall consider the information outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

6. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternative to bed rail use, and that the interventions or

changes are trialed if appropriate and dependent on the resident's assessment, during a specified observation period prior to the application of any bed rails or prior to the removal from use of any bed rails.

7. Ensure that the interdisciplinary team clearly documents the resident assessments/reassessments, including the risk-benefit analysis, as prescribed by the 2003 FDA clinical guidance document, and ensuing recommendation. As per the 2003 FDA clinical guidance document, if clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower that that of other interventions or of not using them, bed rails may be indicated for use. The use of bed rails is to be approved by the interdisciplinary team. The names of the team members who participate in the assessment and decision making process is to be documented.

8. Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team. Where bed rails are to be used, include all required information as specified in the FDA 2003 clinical guidance document, such as related to the use of bed rails for a medical symptom or condition vs. bed rails used for a resident's mobility and/or transferring. Specify how the bed rails are to be used, and when.

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

Grounds / Motifs :

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

On April 13, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Resident Quality Inspection (RQI) #2017_627138_0009. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by July 07, 2017.

Parts 1 and 2 of the compliance order were related to residents' bed systems and parts 3 to 8 of the compliance order were related to the assessment of residents. The parts of the compliance order that have not been complied with will be referenced and addressed below.

Part 1 and part 2 of the compliance order required the licensee to take the following actions:

1. Re-evaluate all bed systems where bed rails are used in the home, in accordance with evidence-based practices. All reassessment are to be documented.

2. Establish and implement a process for ensuring that any bed system failures are addressed immediately by taking the necessary corrective actions. All actions taken to address bed system failures are to be documented.

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

Related to part 1 of the compliance order:

On November 7, 2017, in discussion with the Chief Operating Officer (COO), the Director of Nursing (DON), and Registered Nurse (RN) #101, it was established that entrapment zones 1-4 on all resident bed systems had not been evaluated in accordance with the tests described in the HC guidance document. RN #101, identified as the lead for the bed entrapment team, explained that in response to part one of the compliance order, all residents' bed systems had been observed with a focus on addressing zone 7 gaps. As well, RN #101 indicated that zone 6 was

observed and zone 3 was measured with a tape measure. RN #101 explained that the overall focus was in ensuring a proper fit between the mattress and the bed frame, and ensuring that measures were in place to prevent mattresses from sliding. It was confirmed that evaluating entrapment zones 1-4 in accordance with the tests described in the HC guidance document had not been a consideration.

Related to part 2 of the compliance order:

On November 7, 2017, in discussion with the Chief Operating Officer (COO), the Director of Nursing (DON), and RN #101, RN#101 explained that a bed system failure was understood to be related to a mattress that did not fit the bed frame, or to a mattress that was not prevented from sliding. It was confirmed that entrapment zone 1-4 failures had not been a consideration, as the prescribed testing process did not occur as per the HC guidance document. The Inspector was informed that mattresses were changed as required, and solutions to prevent mattresses from sliding were implemented.

Related to the assessment of residents where bed rails are used:

As previously referenced, all LTC homes have been directed to use the HC guidance document as a best practice document. The HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered and are specified. The process is to result in a documented risk benefit assessment, prior to the team's conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:

a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.

b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.

c) Comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident.

The 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

Part 3 of the compliance order required the licensee to take the following action:

3. Develop and implement a documented multidisciplinary team assessment process for all residents with one or more bed rails in use (including partial rails), and for all residents for which the use of one or more bed rails are being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003)". As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

With regards to a documented team assessment process:

On November 7, 2017, during a discussion with the Director of Nursing (DON) and RN #101, the Inspector was provided with a copy of the home's new assessment tool titled "Bed Entrapment Risk Assessment – V5" which was to be completed by registered nursing staff. It was noted that the assessment form did not include a section to document the names of the team members that participated in the assessment. RN #101 indicated that when all residents' were assessed in response

to the compliance order, it was expected that registered staff spoke with Personal Support Workers (PSWs) about the resident when completing the assessment. For new residents, RN #101 indicated that the assessment would be done within 24 hours of admission and that registered nursing staff would be expected to speak with the PSWs. The DON indicated that all new residents are assessed by the Physiotherapy department for transfer status, and this could also be a source of information for the registered staff when completing the assessment as well.

On November 8, 2017, the Inspector observed resident #001 in his/her bed with two bed rails in the up position. The Inspector subsequently interviewed Registered Nurse (RN) # 102 about her assessment of resident #001, related to bed rail use, upon his/her admission to the home in 2017. The RN indicated that no other staff members were involved in the assessment process.

On November 9, 2017, the Inspector observed resident #003's bed system and it was noted that there were two bed rails in the up position. The Inspector subsequently interviewed RN #103 about her assessment of resident #003, related to bed rail use, following his/her admission to the home in 2017. The RN indicated that no other staff members were involved in the assessment process.

Further related to resident #003, on November 9, 2017, RN #103 confirmed that she had completed the "Bed Entrapment Risk Assessment – V5" tool for the resident twelve days following his/her admission to the home. RN #103 confirmed that despite this, bed rails were in use for resident #003 as of the day the resident was admitted to the home. On November 14, 2017, PSW #109 confirmed that bed rails had been in use for resident #003 since the day the resident was admitted to the home. As per the 2003 FDA Clinical Guidance document, a team assessment process, as prescribed, is to occur prior to the implementation of bed rail use for a resident.

On November 10, 2017, the Inspector observed resident #005's bed system and it was noted that there were two bed rails in the up position. The Inspector subsequently interviewed RN #104 about her assessment of resident #005, related to bed rail use, following his/her admission to the home in 2017. The RN indicated that no other staff members were involved in the assessment process.

With regards to the resident assessment and inclusion of all factors, elements and conditions as outlined in the 2003 FDA Clinical Guidance document:

On November 7, 2017, upon review of the "Bed Entrapment Risk Assessment V5" form with the DON and RN #101, it was noted that all of the factors to be included in the individual resident assessment, as per the 2003 FDA Clinical Guidance document, were not captured. For example, there were no questions related to sleep habits, medication, and ability to toilet self safely. The DON and RN #101 indicated that medication and ability to toilet self safely were factors that had not been incorporated into the assessment process. Related to sleep habits, RN #101 indicated that it was expected that registered nursing staff would know to consider this factor when completing an assessment. RN #101 indicated that there was a need to specifically include sleep habits into the assessment tool to ensure it was captured.

On November 10, 2017, RN#104 and the Inspector reviewed all of the factors to be considered as outlined in the 2003 FDA Clinical Guidance document. RN#104 indicated that sleep habits and medications were two factors that she would not have considered when completing resident #005's initial assessment related to bed rail use, nor would she have considered these factors for other residents she had assessed.

Part 4 of the compliance order required the licensee to take the following action:

4. Ensure that the multidisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternative to bed rail use, and that the interventions or changes are trialed if appropriate and dependent on the resident's assessment, during a specified observation period prior to the application of any bed rails or prior to the removal from use of any bed rails.

On November 7, 2017, RN #101 indicated that the resident assessment process implemented with regards to bed rail use does not result in the consideration of alternatives to bed rail use or the trialing of alternatives to bed rail use, if appropriate, prior to the application of bed rails.

On November 9, 2017, RN #103 and the Inspector discussed the RN's assessment of resident #003 following his/her admission to the home in 2017. RN #103 indicated that there had been no consideration of alternatives to bed rail use for resident #003.

On November 10, 2017, RN #104 and the Inspector discussed the RN's assessment of resident #005 following his/her admission to the home in 2017. RN #104 indicated that there had been no consideration of alternatives to bed rail use for resident #005. RN #104 indicated that the assessment process does not lead to the consideration of alternatives to bed rail use.

Part 6 of the compliance order required the licensee to take the following action:

6. Ensure that the multidisciplinary team clearly documents the final results of the assessment/reassessment, including the risk-benefit analysis and ensuing recommendation.

On November 7, 2017, the DON and RN #101 indicated that the assessment process implemented with regards to bed rail use does not result in a team clearly documenting the final results of the assessment/reassessment, including the risk benefit analysis and the ensuing recommendations.

Related to the notion of a documented assessment including a risk benefit analysis, the Inspector found that for two residents with bed rails in use at the time of the inspection, there was no documented assessment within the resident's health care record. The Inspector did locate reference to the use of bed rails for both residents within an admission note, made by RN #102, on the residents' respective admission dates.

On November 9, 2017, the Inspector observed resident #002's bed system and it was noted that there were two bed rails in the up position. On November 10, 2017, the Inspector observed resident #004's bed system and it was noted that there were two bed rails in the up position.

On November 10, 2017, the Inspector interviewed RN #102 about her implementation of bed rail use for resident #002 and #004. The RN indicated that on the residents' respective admission days, she would have developed a general understanding of the potential risks and benefits related to bed rail use for the respective residents, based on observation and discussion with the residents and the family. The RN indicated she would have discussed those potential risks and benefits with the family during the admission process, and then the family would have informed the RN if bed rails were to be used. The RN indicated she could not recall specific details related to either resident, however, upon review of the admission

notes, the RN confirmed that bed rails had been put into use for both residents on their respective admission dates. The RN confirmed that she did not complete the "Bed Entrapment Risk Assessment" tool for resident #002 and #004. As per the 2003 FDA Clinical Guidance document, a team assessment process, as prescribed, is to occur prior to the implementation of bed rail use for a resident.

Related to the notion of documented recommendations:

On November 8, 9 and 14, 2017, RN #102, RN #103 and RN #104, respectively, informed the Inspector that they do not make recommendations related to bed rail use. The RN's indicated that they discuss the risks and benefits of bed rail use with the resident and or the resident's family, and then the resident or the resident's family decides if bed rails are to be used.

Part 7 of the compliance order required the licensee to take the following action:

7. Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team. Include all required information as specified in the FDA 2003 clinical guidance document, such as related to the use of bed rails for a medical symptom or condition vs. bed rails used for a resident's mobility and/or transferring.

The Inspector first observed that bed rails were in use for resident #001 on November 8, 2017. Resident #001's health care record was reviewed on November 8, 2017 and again on November 14, 2017. The written care plan, the care plan kardex and the MDS kardex for resident #001 did not include reference to the use of bed rails.

The Inspector first observed that bed rails were in use for resident #002 on November 9, 2017. Resident #002's health care record was reviewed on November 9, 2017 and again on November 14, 2017. The written care plan and associated kardex for resident #002 did not include reference to the use of bed rails. The MDS kardex reflected that bed rails were in use for bed mobility or transfer.

The Inspector first observed that bed rails were in use for resident #004 on November 10, 2017. Resident #004's health care record was reviewed on November 9, 2017 and again on November 14, 2017. The written care plan and associated kardex for resident #004 did not include reference to the use of bed rails.

The MDS kardex reflected that bed rails were in use for bed mobility or transfer.

On November 14, 2017, Personal Support Worker Supervisor #105 (PSWS) indicated that Personal Support Workers (PSW) have access to residents' written care plans, which are printed and placed in a binder at the nurses' stations, and to the associated care plan kardex on laptops or through the Point of Care terminals. PSWS #105 indicated that the MDS kardex is not printed off for the PSWs to review and PSWs are not expected to consult the MDS kardex.

Further related to resident #001, on November 14, 2017, the Inspector asked PSW #108 about the resident's use of bed rails. PSW #108 reviewed the resident's care plan kardex on a Point of Care terminal and indicated that there was no reference to bed rail use for the resident. PSW #108 indicated that this was her main source for information. PSW #108 then reviewed resident #001's printed care plan in a binder at the nurses' station and indicated that there was no reference to bed rail use for the resident. PSW #108 indicated that she was told last week that it was safer to have bed rails in use for resident #001. PSW #108 indicated that the two bed rails are up at all times for resident #001.

Further related to resident #002, on November 9, 2017, PSW #106 indicated to the Inspector that the resident does not use bed rails for bed mobility or transfers, as was indicated in the MDS kardex. PSW #106 indicated that the resident is a very nervous and anxious person and that the resident always holds on to the left bed rail when sleeping.

Further related to resident #004, on November 14, 2017, PSW #107 indicated to the Inspector that the resident does not use bed rails for bed mobility or transfers, as was indicated in the MDS kardex. PSW #107 indicated that she assumed that the bed rails were in use for resident #004 for overall safety, as the resident does not use the bed rails. PSW #107 reviewed the resident #004's care plan and the associated care plan kardex and noted that the use of bed rails was not referenced. PSW #107 indicated that she assumed that registered nursing staff had forgotten to include use of bed rails in the resident's care plan, as bed rails had been in use for the resident since the resident's admission to the home.

In summary, the licensee has failed to comply with all aspects of Compliance Order #001, issued as a result of Resident Quality Inspection #2017_627138_0009. As a result of the continuing widespread non-compliance, which presents the potential for

actual harm, a subsequent Compliance Order will be served to the licensee. [s. 15. (1) (a)] (133)

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

Jun 29, 2018(A1)

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 6 day of February 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JESSICA LAPENSEE

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Service Area Office / Bureau régional de services : Ottawa