Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

**Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée***


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

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

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## Amended Public Copy/Copie modifiée du public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 12, 2019 | 2019_625133_0012 (A1) | 001102-19 | Follow up |

### Licensee/Titulaire de permis

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Amended by JESSICA LAPENSEE (133) - (A1)

### Amended Inspection Summary/Résumé de l'inspection modifié

**The compliance order due date has been amended upon request from the licensee. The compliance order due date was September 13, 2019. The compliance order due date has been extended to December 13, 2019. No other changes have been made.**

**Issued on this 12nd day of September, 2019 (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**

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

# Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*


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Sherwood Park Manor
1814 County Road #2 East BROCKVILLE ON K6V 5T1

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

Amended by JESSICA LAPENSEE (133) - (A1)

## Amended Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): May 7, 9, 10, 21, 2019**

**The following intake was completed in the Follow Up inspection: Log #001102-19, which was related to bed rail use.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Assistant Director of Care, the Maintenance Manager, registered and non-registered nursing staff, and residents.**

**During the course of the inspection, the Inspector observed residents' bed systems, observed identified residents in bed with bed rails in use, observed entrapment zone testing conducted**

**by the Maintenance Manager, reviewed documentation related to bed system evaluations, reviewed residents' health care records.**

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

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

| **NON-COMPLIANCE / NON - RESPECT DES EXIGENCES** | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

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

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

**Findings/Faits saillants :**

1. The licensee has failed to comply with compliance order (CO) #001 from Resident Quality Inspection #2018_765541_0017. The CO report date was January 4, 2019, and the CO had a compliance due date (CDD) of March 31, 2019. The CO was amended, as per request from the licensee, on January 29, 2019. The amendment was in relation to the CDD, which was extended to April 30, 2019.

The licensee was ordered to comply with O. Reg. 79/10, s. 15 (1), and, to specifically comply with the following items:

1) Ensure that bed rail use for resident #008, #020, #049 and any other resident is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) (FDA clinical guidance document). This includes, but is not limited to:

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

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

c) Documented approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment and the final risk benefit assessment. The names of the team members are to be documented.

2) Ensure that steps are taken and documented to prevent resident entrapment for residents #017, #018, #020, #051, #052 and any other resident, taking into consideration all potential zones of entrapment.

3) Update the written plan of care based on the resident's assessment/reassessment by the interdisciplinary team. Provide clear directions as to how the bed rails on a resident's bed are to be used, when they are to be used, and in what position they are to be used. Include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

The licensee failed to comply with O. Reg. 79/10, s. 15 (1) for the reasons set out below, and, because bed systems with bed rails in use were not evaluated in accordance with evidence based practices, to minimize risk to the residents. Bed system evaluation includes testing entrapment zones 1, 2, 3 and 4 as prescribed by Health Canada (HC) in the HC guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

The licensee failed to complete steps 1a, b, and c, in that bed rail use was implemented for resident #011 upon their admission to the home, without the approval of the interdisciplinary team, and, in the absence of the prescribed resident assessment, and subsequent risk benefit assessment.

In relation to step 2, bed systems that the licensee understood to pass entrapment zone testing were put into place for the five identified residents (#017, #018, #051, #052, #020). Additional non-compliance related to the licensee's failure to take steps to prevent entrapment for other identified residents was identified over the course of this Follow Up inspection.

The licensee completed step 3 in that the current care plan in place for the seven residents referenced in the CO (#017, #018, #051, #052, #020, #008, #049) made note of the type of bed rails in use for each resident.

In relation to evidence based and prevailing practices:

In August, 2012, the Ministry of Health and Long-Term Care (MOHLTC) issued a memo to all Long-Term Care Home Administrators about the risk of bed-related

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

The HC guidance document includes the titles of two additional companion documents. The referenced companion documents are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is a clinical practice guideline, titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used. The other companion document is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006, FDA".

On March 27, 2019, the MOHLTC issued another memo to the Long-Term Care Home sector about the use of bed rails in long-term care homes. The memo included reference and links to the three documents noted above, and a summary of expectations related to assessing residents and evaluating bed systems.

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

On May 9th, 2019, as a result of discussion with the Assistant Director of Care (ADOC, #101) and the Maintenance Manager (MM, #102), and demonstration by the MM, it was determined that the entrapment zones on all of the residents' bed systems had not been tested in accordance with the HC guidance document. A

bed system evaluation includes testing entrapment zones 1, 2, 3 and 4, as prescribed by HC guidance document.

On May 9th, 2019, in the presence of Inspector #133 and the ADOC, the MM tested entrapment zones 1, 2, 3 and 4 on resident # 006's bed system, in accordance with the HC guidance document. The bed frame was identified by the MM and ADOC (type A), with ¾ length rails. It was noted that the right rail was loose. It was noted that the resident's mattress was an older, softer type of mattress. Entrapment zones 2, 3 and 4 failed the prescribed tests, on both sides.

On May 9th, 2019, in the presence of Inspector #133 and the ADOC, the MM tested entrapment zones 1, 2, 3 and 4 on resident #007's bed system. Resident # 007's bed frame and bed rails were the same as resident #006's. Resident #007 had a newer, firmer style of mattress in place. Entrapment zones 2 and 4 failed the prescribed tests, on both sides. On May 10th, 2019, the MM showed Inspector #133 a reference document that they kept with them when conducting bed system evaluations. The document related to bed rail options for the type of bed frame in use for resident #006 and #007 (type A). The document included pictures of seven types of bed rails (A-G). The types of rails in use on resident #006 and #007's bed frame, picture E, were noted to be acceptable for use with a retro fit kit. The MM indicated that they had thought that retro fit kits were in place, however, they now understood that they were not. As per the "Facility Entrapment Inspection Sheet December 6 2018" document created by the MM, there were approximately 20 bed systems in the home that included the type A bed frame and the bed rails shown in picture E.

On May 9th, 2019, in the presence of Inspector #133 and the ADOC, the MM tested entrapment zones 1, 2, 3 and 4 for one of the four bed rails on resident # 009's bed system. Resident #009's identified type of bed frame (type B) had an identified type of bed rail in use, on both sides. Entrapment zones 2, 3 and 4, failed the prescribed entrapment zone testing on one of the identified rails. Another resident with a type B bed frame and the same type of bed rails, resident # 010, had a mattress that did not fit the bed frame. The mattress was too narrow for the frame, leaving gaps along either side. The ADOC and the MM indicated that when resident #010's bed system was last evaluated, in December 2018, the mattress in place did fit the frame. The ADOC and the MM were unable to determine where the resident's mattress had gone. Resident #010 was provided with a new bed system on May 10, 2019, that did pass evaluation.

In summary, it was determined that where bed rails are used, the residents' bed systems had not been evaluated in accordance with evidence based practices, to minimize risk to the residents. When three residents' bed systems were evaluated as prescribed, during the inspection, at least two entrapment zones failed testing on all three bed systems.

Related to the documentation of bed system evaluations, including testing results for entrapment zones 1, 2, 3 and 4.

On May 10, 2019, Inspector #133 referenced the "Facility Entrapment Inspection Sheet December 6 2018" as provided by the Maintenance Manager (MM, #102) to determine the location of bed systems that included an air mattress, for observation. Information included about the home's bed system inventory was as follows (the inventory): room number, bed number, serial number, type of rail(s) tested, if the rail(s) was loose, type of bed frame, mattress type, if the mattress had a perimeter edge, entrapment zone 1, 2, 3, 4, 5, 6, and 7 testing or evaluation results, if there was a mattress keeper/corner in place, if there was a rail cap, and comments/reasons for failure. Inspector #133 observed two bed systems that did include an air mattress, as per the inventory, that did not include an air mattress at the time of the inspection. Inspector #133 observed three bed systems that did not include an air mattress, as per the inventory, that did include an air mattress at the time of the inspection. The MM indicated to Inspector #133 that they were aware that some mattresses had been moved around since they had last updated the inventory. The MM clarified that the inventory had last been updated in December 2018, when they had last evaluated all bed systems in the home. The MM indicated that they could not say how many mattresses had been switched around since December 2018. The MM indicated that they thought that they had evaluated new bed systems resulting from mattress changes. The MM confirmed that they did not record the bed system evaluations and had not updated the inventory.

In summary, not all bed system evaluations were documented and a current bed system inventory had not been maintained.

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

As per the Health Canada Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", the term entrapment describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. Resident entrapments may result in deaths and serious injuries. The FDA clinical guidance document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) discusses the risk of entrapment when a resident slips between the mattress and bed rail, or when a resident becomes entrapped in the bed rail itself. The population at risk for entrapment are residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement hypoxia, fecal impaction and acute urinary retention that cause them to move about the bed or try to exit from the bed.

On May 21, 2019, Inspector #133 interviewed the Life Enrichment Assistant (LEA) #105, a member of the established interdisciplinary team (the team) that assessed all residents and made decisions about bed rail use. Over the course of the interview, the LEA demonstrated an understanding of the term entrapment that was not in line with that which is referenced above.

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

Resident #011 was admitted to the home on an identified date in 2019. As per discussion on May 10, 2019 with Registered Practical Nurse (RPN) #103, who was involved with the resident's admission, the resident requested that bed rails be put into use on admission day and therefore that is what occurred. The RPN (#103) indicated that the admission process did not include an assessment of risk

related to bed rail use. On May 10, 2019 the Assistant Director of Care (ADOC) #101, a member of the team, indicated that as resident #011 had requested the use of bed rails, alternatives to bed rails would not have been considered. On May 21, 2019, Inspector #133 confirmed that bed rails remained in use for resident #011. It was confirmed that the team had not yet completed an assessment of resident #011, had not conducted a subsequent risk benefit assessment, and had not approved of the use of bed rails.

In summary, resident #011 was not assessed in accordance with prevailing practices, to minimize risks to the resident, prior to the implementation of bed rail use for the resident.

Related to steps to be taken to prevent entrapment, taking into consideration all potential zones of entrapment:

On May 9, 2019, Inspector #133, Assistant Director of Care (ADOC) #101 and the Maintenance Manager (MM) #102 observed resident #012's bed system. The resident's bed system included ¾ rails and an air mattress that did not have a perimeter encompassing the air cells. The MM and the ADOC indicated that all air mattress in the home were of this design. The MM indicated that they had assessed entrapment zone 6 and tested entrapment zone 1 on all residents' bed systems with an air mattress in place. The ADOC indicated that the other entrapment zones would not have been tested as it was their understanding that they would not pass the prescribed testing. The MM indicated that they had mistakenly documented that all entrapment zones on resident #012's bed system had been tested and had passed. The MM proceeded to conduct entrapment zone testing, on the left side rail of resident #012's bed system, to verify if there was a possibility some could pass. The MM tested entrapment zone 2, and it passed (type C). Entrapment zone 3 was tested, and it failed. Entrapment zone 4 was also tested, and it passed. As per discussion with the ADOC, steps had not been taken to prevent entrapment for resident #012, taking into consideration entrapment zone 3. The ADOC indicated that it had not been previously understood that steps were to be taken to prevent entrapment, taking into consideration all potential zones of entrapment, for residents with such air mattresses in use. The ADOC indicated that for some residents, regardless of the type of mattress, accessories such a rail pads were in use to prevent the resident's legs and/or arms from going through the rails (entrapment zone 1).

On May 10, 2019, Inspector #133 observed resident #008 in bed, on an air mattress. Two ¾ rails were up. The same bed frame (type A) and rails that were in place for resident #006 and #007 were in place for resident #008. Inspector #133 observed that there were no modifications or accessories in place to prevent the resident's entrapment. The resident's current care plan was reviewed and it did not include reference to any steps to be taken to prevent the resident's entrapment.

On May 21, 2019, Inspector #133 observed resident #013 in bed, on an air mattress. There were two bed rails in use (identified). The same bed frame (type A) that was in place for resident #006, #007 and #008 was in place for resident #013. Inspector #133 observed that there were no modifications or accessories in place to prevent the resident's entrapment. The resident's current care plan was reviewed and it did not include reference to any steps to be taken to prevent the resident's entrapment.

In summary, steps were not taken to prevent entrapment, taking into consideration all potential zones of entrapment, for residents #008, #012, #013.

In conclusion, the decision to reissue this compliance order was based on the following:

The severity of the non-compliance identified was such that there was actual risk of harm to residents, including resident #006, #007, #008, #009, #010, #011, #012 and #013.

The scope of the non-compliance identified was widespread. All of the residents' bed systems have bed rails on them and entrapment zone testing was not conducted in accordance with evidenced based practices on any bed system prior to the inspection. During the inspection, five residents' (#006, #007, #009, #010, #012) bed systems failed entrapment zone testing in one or more of the zones. Steps were not taken to prevent entrapment for the three residents reviewed (#012, #008 and #013) with bed systems that included an air mattress. The one resident (#011) admitted to the home following the compliance order due date (April 30, 2019) had bed rails implemented for use immediately upon admission, in the absence of an assessment process as prescribed.

The licensee had a compliance history, in that the Compliance Order (CO) is being reissued to the same section and subsection, O. Reg. 79/10, s. 15 (1),

related to bed rail use. CO #001 was served to the licensee in January 2019 as a result of Resident Quality Inspection (RQI) #2018_765541_0017. As well, the licensee has been issued an additional three COs within the last 36 months. CO #002, related to plan of care, and CO #003, related to use of equipment in accordance with manufacturer's instructions, were also issued as a result of the RQI. As a result of complaint inspection #2018_702197_0026, CO #001, related to plan of care, was issued to the licensee in January 2019. [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 12nd day of September, 2019 (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

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

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

## Amended Public Copy/Copie modifiée du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l’inspecteur (No) :** | Amended by JESSICA LAPENSEE (133) - (A1) |
| **Inspection No. / No de l’inspection :** | 2019_625133_0012 (A1) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 001102-19 (A1) |
| **Type of Inspection / Genre d’inspection :** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Sep 12, 2019(A1) |
| **Licensee / Titulaire de permis :** | Sherwood Park Manor<br>1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1 |
| **LTC Home / Foyer de SLD :** | Sherwood Park Manor<br>1814 County Road #2 East, BROCKVILLE, ON, K6V-5T1 |
| **Name of Administrator / Nom de l’administratrice ou de l’administrateur :** | Alfred O'Rourke |

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 Sherwood Park Manor, you are hereby required to comply with the following order (s) by the date(s) set out below:

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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**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2018_765541_0017, CO #001;

**Pursuant to / Aux termes de :**

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

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

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

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

**Order / Ordre :**

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

Specifically the licensee must:

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

2. Take immediate corrective action with regards to resident #006, #007 and #009's bed systems, and any other resident's bed system that does not pass the evaluation, including the entrapment zone specific dimensional tests outlined in the HC guidance document. Consider the information outlined in the following prevailing practices document: "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (FDA, 2006). Document the corrective actions taken.

3. Update the bed system inventory with the results of the bed system evaluations and ensure that all subsequent bed system evaluations are documented accordingly. Include reference to any interventions (i.e. modifications, accessories) that are in place to mitigate entrapment areas on a bed system.

4. Develop and implement a written procedure to formally track when components of a bed system (i.e. bed rails or mattresses) are changed or replaced, and, to compel a bed system evaluation when such changes or replacements occur.

5. Ensure that the bed rails in use for resident # 006, and any other resident, are maintained in good repair.

6. Take steps to prevent resident entrapment, for resident #006, #007, #009, #012, #008, #013, and any other resident, taking into consideration all potential zones of entrapment. This includes, but is not limited to:

a) residents with a bed system that includes an air mattress, which cannot pass entrapment zone testing by function of the design of the mattress; and

b) residents with a bed system that does pass entrapment zone testing, where the prescribed resident assessment and subsequent risk benefit assessment (referenced below) identifies a need.

Steps to prevent resident entrapment shall be taken with consideration of the guidance provided in the two FDA prevailing practices documents referenced in this compliance order. These are: "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (FDA, 2006), and, "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003)" (FDA clinical guidance document)

7. Avoid the automatic use of bed rails, as per the FDA clinical guidance document. Ensure that bed rail use, or removal from use, for resident #011, and any other resident, is assessed and implemented in full accordance with

the FDA clinical guidance document. This includes, but is not limited to:

a) A documented individual resident assessment conducted by an interdisciplinary team, including all specified factors, prior to any decision regarding bed rail use or removal from use.

b) A documented risk benefit assessment conducted by the interdisciplinary team, considering all of the information gathered during the individual resident assessment. The documented risk benefit assessment, as per the FDA clinical guidance document, is to include:

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

ii) Compare the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. Consideration of the potential for injury or death with the use of bed rails must include consideration of the risk of entrapment, as outlined in the "Guiding Principles" section of the FDA clinical guidance document.

iii) A final conclusion, if bed rails are used, indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Approval of the use of bed rails for an individual resident by the interdisciplinary team members that conducted the assessment process and made the final decision. The names of the team members, and the rationale, is to be clearly documented.

8. Ensure that all members of the interdisciplinary team that conduct the assessment process and make decisions about bed rail use for residents are familiar with the HC guidance document and the FDA clinical guidance document.

9. Ensure that the written plan of care for resident #011, and any other

resident, provides clear direction as to how and when bed rails are to be used. For resident #011, #006, #007, #009, #012, #008, #013, and any other resident, include in the written plan of care any steps that are to be taken to prevent the resident's entrapment, taking into consideration all potential zones of entrapment.

**Grounds / Motifs :**

1. 1. The licensee has failed to comply with compliance order (CO) #001 from Resident Quality Inspection #2018_765541_0017. The CO report date was January 4, 2019, and the CO had a compliance due date (CDD) of March 31, 2019. The CO was amended, as per request from the licensee, on January 29, 2019. The amendment was in relation to the CDD, which was extended to April 30, 2019.

The licensee was ordered to comply with O. Reg. 79/10, s. 15 (1), and, to specifically comply with the following items:

1) Ensure that bed rail use for resident #008, #020, #049 and any other resident is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) (FDA clinical guidance document). This includes, but is not limited to:

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

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

the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Documented approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment and the final risk benefit assessment. The names of the team members are to be documented.

2) Ensure that steps are taken and documented to prevent resident entrapment for residents #017, #018, #020, #051, #052 and any other resident, taking into consideration all potential zones of entrapment.

3) Update the written plan of care based on the resident's assessment/reassessment by the interdisciplinary team. Provide clear directions as to how the bed rails on a resident's bed are to be used, when they are to be used, and in what position they are to be used. Include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

The licensee failed to comply with O. Reg. 79/10, s. 15 (1) for the reasons set out below, and, because bed systems with bed rails in use were not evaluated in accordance with evidence based practices, to minimize risk to the residents. Bed system evaluation includes testing entrapment zones 1, 2, 3 and 4 as prescribed by Health Canada (HC) in the HC guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards".

The licensee failed to complete steps 1a, b, and c, in that bed rail use was implemented for resident #011 upon their admission to the home, without the approval of the interdisciplinary team, and, in the absence of the prescribed resident assessment, and subsequent risk benefit assessment.

In relation to step 2, bed systems that the licensee understood to pass entrapment zone testing were put into place for the five identified residents (#017, #018, #051, #052, #020). Additional non-compliance related to the licensee's failure to take steps to prevent entrapment for other identified residents was identified over the course of this Follow Up inspection.

The licensee completed step 3 in that the current care plan in place for the seven

residents referenced in the CO (#017, #018, #051, #052, #020, #008, #049) made note of the type of bed rails in use for each resident.

In relation to evidence based and prevailing practices:

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

The HC guidance document includes the titles of two additional companion documents. The referenced companion documents are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. One of the companion documents is a clinical practice guideline, titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, FDA, 2003" (FDA clinical guidance document). The FDA clinical guidance document outlines a process that is to be followed with regards to the decision to use or discontinue use of bed rails for a resident. This process includes the formation of an interdisciplinary team, individualized resident assessment including all specified factors by the team, a subsequent risk-benefit assessment documented within the resident's health care record, and approval by the team if bed rails are to be used. The other companion document is titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006, FDA".

On March 27, 2019, the MOHLTC issued another memo to the Long-Term Care Home sector about the use of bed rails in long-term care homes. The memo included reference and links to the three documents noted above, and a summary of expectations related to assessing residents and evaluating bed systems.

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

On May 9th, 2019, as a result of discussion with the Assistant Director of Care (ADOC, #101) and the Maintenance Manager (MM, #102), and demonstration by the MM, it was determined that the entrapment zones on all of the residents' bed systems had not been tested in accordance with the HC guidance document. A bed system evaluation includes testing entrapment zones 1, 2, 3 and 4, as prescribed by HC guidance document.

On May 9th, 2019, in the presence of Inspector #133 and the ADOC, the MM tested entrapment zones 1, 2, 3 and 4 on resident # 006's bed system, in accordance with the HC guidance document. The bed frame was identified by the MM and ADOC (type A), with ¾ length rails. It was noted that the right rail was loose. It was noted that the resident's mattress was an older, softer type of mattress. Entrapment zones 2, 3 and 4 failed the prescribed tests, on both sides.

On May 9th, 2019, in the presence of Inspector #133 and the ADOC, the MM tested entrapment zones 1, 2, 3 and 4 on resident #007's bed system. Resident # 007's bed frame and bed rails were the same as resident #006's. Resident #007 had a newer, firmer style of mattress in place. Entrapment zones 2 and 4 failed the prescribed tests, on both sides. On May 10th, 2019, the MM showed Inspector #133 a reference document that they kept with them when conducting bed system evaluations. The document related to bed rail options for the type of bed frame in use for resident #006 and #007 (type A). The document included pictures of seven types of bed rails (A-G). The types of rails in use on resident #006 and #007's bed frame, picture E, were noted to be acceptable for use with a retro fit kit. The MM indicated that they had thought that retro fit kits were in place, however, they now understood that they were not. As per the "Facility Entrapment Inspection Sheet December 6 2018" document created by the MM, there were approximately 20 bed systems in the home that included the type A bed frame and the bed rails shown in picture E.

On May 9th, 2019, in the presence of Inspector #133 and the ADOC, the MM tested entrapment zones 1, 2, 3 and 4 for one of the four bed rails on resident # 009's bed system. Resident #009's identified type of bed frame (type B) had an identified type

of bed rail in use, on both sides. Entrapment zones 2, 3 and 4, failed the prescribed entrapment zone testing on one of the identified rails. Another resident with a type B bed frame and the same type of bed rails, resident # 010, had a mattress that did not fit the bed frame. The mattress was too narrow for the frame, leaving gaps along either side. The ADOC and the MM indicated that when resident #010's bed system was last evaluated, in December 2018, the mattress in place did fit the frame. The ADOC and the MM were unable to determine where the resident's mattress had gone. Resident #010 was provided with a new bed system on May 10, 2019, that did pass evaluation.

In summary, it was determined that where bed rails are used, the residents' bed systems had not been evaluated in accordance with evidence based practices, to minimize risk to the residents. When three residents' bed systems were evaluated as prescribed, during the inspection, at least two entrapment zones failed testing on all three bed systems.

Related to the documentation of bed system evaluations, including testing results for entrapment zones 1, 2, 3 and 4.

On May 10, 2019, Inspector #133 referenced the "Facility Entrapment Inspection Sheet December 6 2018" as provided by the Maintenance Manager (MM, #102) to determine the location of bed systems that included an air mattress, for observation. Information included about the home's bed system inventory was as follows (the inventory): room number, bed number, serial number, type of rail(s) tested, if the rail (s) was loose, type of bed frame, mattress type, if the mattress had a perimeter edge, entrapment zone 1, 2, 3, 4, 5, 6, and 7 testing or evaluation results, if there was a mattress keeper/corner in place, if there was a rail cap, and comments/reasons for failure. Inspector #133 observed two bed systems that did include an air mattress, as per the inventory, that did not include an air mattress at the time of the inspection. Inspector #133 observed three bed systems that did not include an air mattress, as per the inventory, that did include an air mattress at the time of the inspection. The MM indicated to Inspector #133 that they were aware that some mattresses had been moved around since they had last updated the inventory. The MM clarified that the inventory had last been updated in December 2018, when they had last evaluated all bed systems in the home. The MM indicated that they could not say how many mattresses had been switched around since December 2018. The MM

indicated that they thought that they had evaluated new bed systems resulting from mattress changes. The MM confirmed that they did not record the bed system evaluations and had not updated the inventory.

In summary, not all bed system evaluations were documented and a current bed system inventory had not been maintained.

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

As per the Health Canada Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards", the term entrapment describes an event in which a resident is caught, trapped, or entangled in the space in or about the bed rail. Resident entrapments may result in deaths and serious injuries. The FDA clinical guidance document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) discusses the risk of entrapment when a resident slips between the mattress and bed rail, or when a resident becomes entrapped in the bed rail itself. The population at risk for entrapment are residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement hypoxia, fecal impaction and acute urinary retention that cause them to move about the bed or try to exit from the bed.

On May 21, 2019, Inspector #133 interviewed the Life Enrichment Assistant (LEA) #105, a member of the established interdisciplinary team (the team) that assessed all residents and made decisions about bed rail use. Over the course of the interview, the LEA demonstrated an understanding of the term entrapment that was not in line with that which is referenced above.

As per the FDA clinical guidance document: The automatic use of bed rails may pose unwarranted hazards to resident safety. Decisions to use or discontinue use of bed rails is to be made in the context of an individual resident assessment using an interdisciplinary team with input from the resident and family or the resident's legal representative. The factors to be included in the resident assessment are prescribed. Following the resident assessment, a risk benefit assessment (as prescribed) is to be documented in the resident's health care record. The use of bed rails is to be based

on the resident's assessed medical needs, documented clearly and approved by the interdisciplinary team. If clinical and environmental interventions have proven unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bedrail use is lower than that of other interventions or of not using them, bed rails may be used.

Resident #011 was admitted to the home on an identified date in 2019. As per discussion on May 10, 2019 with Registered Practical Nurse (RPN) #103, who was involved with the resident's admission, the resident requested that bed rails be put into use on admission day and therefore that is what occurred. The RPN (#103) indicated that the admission process did not include an assessment of risk related to bed rail use. On May 10, 2019 the Assistant Director of Care (ADOC) #101, a member of the team, indicated that as resident #011 had requested the use of bed rails, alternatives to bed rails would not have been considered. On May 21, 2019, Inspector #133 confirmed that bed rails remained in use for resident #011. It was confirmed that the team had not yet completed an assessment of resident #011, had not conducted a subsequent risk benefit assessment, and had not approved of the use of bed rails.

In summary, resident #011 was not assessed in accordance with prevailing practices, to minimize risks to the resident, prior to the implementation of bed rail use for the resident.

Related to steps to be taken to prevent entrapment, taking into consideration all potential zones of entrapment:

On May 9, 2019, Inspector #133, Assistant Director of Care (ADOC) #101 and the Maintenance Manager (MM) #102 observed resident #012's bed system. The resident's bed system included ¾ rails and an air mattress that did not have a perimeter encompassing the air cells. The MM and the ADOC indicated that all air mattress in the home were of this design. The MM indicated that they had assessed entrapment zone 6 and tested entrapment zone 1 on all residents' bed systems with an air mattress in place. The ADOC indicated that the other entrapment zones would not have been tested as it was their understanding that they would not pass the prescribed testing. The MM indicated that they had mistakenly documented that all entrapment zones on resident #012's bed system had been tested and had passed.

The MM proceeded to conduct entrapment zone testing, on the left side rail of resident #012's bed system, to verify if there was a possibility some could pass. The MM tested entrapment zone 2, and it passed (type C). Entrapment zone 3 was tested, and it failed. Entrapment zone 4 was also tested, and it passed. As per discussion with the ADOC, steps had not been taken to prevent entrapment for resident #012, taking into consideration entrapment zone 3. The ADOC indicated that it had not been previously understood that steps were to be taken to prevent entrapment, taking into consideration all potential zones of entrapment, for residents with such air mattresses in use. The ADOC indicated that for some residents, regardless of the type of mattress, accessories such a rail pads were in use to prevent the resident's legs and/or arms from going through the rails (entrapment zone 1).

On May 10, 2019, Inspector #133 observed resident #008 in bed, on an air mattress. Two ¾ rails were up. The same bed frame (type A) and rails that were in place for resident #006 and #007 were in place for resident #008. Inspector #133 observed that there were no modifications or accessories in place to prevent the resident's entrapment. The resident's current care plan was reviewed and it did not include reference to any steps to be taken to prevent the resident's entrapment.

On May 21, 2019, Inspector #133 observed resident #013 in bed, on an air mattress. There were two bed rails in use (identified). The same bed frame (type A) that was in place for resident #006, #007 and #008 was in place for resident #013. Inspector #133 observed that there were no modifications or accessories in place to prevent the resident's entrapment. The resident's current care plan was reviewed and it did not include reference to any steps to be taken to prevent the resident's entrapment.

In summary, steps were not taken to prevent entrapment, taking into consideration all potential zones of entrapment, for residents #008, #012, #013.

In conclusion, the decision to reissue this compliance order was based on the following:

The severity of the non-compliance identified was such that there was actual risk of harm to residents, including resident #006, #007, #008, #009, #010, #011, #012 and #013.

The scope of the non-compliance identified was widespread. All of the residents' bed systems have bed rails on them and entrapment zone testing was not conducted in accordance with evidenced based practices on any bed system prior to the inspection. During the inspection, five residents' (#006, #007, #009, #010, #012) bed systems failed entrapment zone testing in one or more of the zones. Steps were not taken to prevent entrapment for the three residents reviewed (#012, #008 and #013) with bed systems that included an air mattress. The one resident (#011) admitted to the home following the compliance order due date (April 30, 2019) had bed rails implemented for use immediately upon admission, in the absence of an assessment process as prescribed.

The licensee had a compliance history, in that the Compliance Order (CO) is being reissued to the same section and subsection, O. Reg. 79/10, s. 15 (1), related to bed rail use. CO #001 was served to the licensee in January 2019 as a result of Resident Quality Inspection (RQI) #2018_765541_0017. As well, the licensee has been issued an additional three COs within the last 36 months. CO #002, related to plan of care, and CO #003, related to use of equipment in accordance with manufacturer's instructions, were also issued as a result of the RQI. As a result of complaint inspection #2018_702197_0026, CO #001, related to plan of care, was issued to the licensee in January 2019. [s. 15. (1) (a)]
(133)

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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

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

## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  12nd  day of September, 2019 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :**

Amended by JESSICA LAPENSEE (133) - (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

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