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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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ Registre no	Type of Inspection / Genre d'inspection
Aug 11, 2017;	2017_539120_0016 (A1)	004648-17	Critical Incident System

Licensee/Titulaire de permis

Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive Suite 700 MISSISSAUGA ON L5R 4H1

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

Chartwell Willowgrove Long Term Care Residence
1217 Old Mohawk Road ANCASTER ON L9K 1P6

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

BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date for order #001 has been amended.

Issued on this 11 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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BERNADETTE SUSNIK (120) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

This inspection was conducted on the following date(s): February 28, 2017

Critical Incident 2921-000007-17 related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Director of Care, registered staff, and personal support workers.

During the course of the inspection, the inspector toured the 2nd floor, observed the bed systems in the home, reviewed the home's falls prevention policy, bed safety policies and procedures, bed entrapment audit results and resident clinical records.

The following Inspection Protocols were used during this inspection:

Falls Prevention

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

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidelines includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources".

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. 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, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered

to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this inspection, four residents (#100-103) were selected for review to determine whether they were assessed for bed rail safety in accordance with the Clinical Guidance document and if any safety risks were identified and mitigated.

According to the licensee's "Bed System Assessment" (LTC-CA-ON-200-07-22) policy dated January 2016, and confirmed by several registered practical nurses and several personal support workers (PSWs), residents who were newly admitted were not required to be observed while sleeping for a period of time with and without bed rails. The policy directed registered staff to complete a form titled "Bed System Assessment" (BSA) "before the resident was put to bed for their first night", discuss the risks associated with bed rails, if at the conclusion the bed rails were to be used, the nurse would instruct the resident on the use of the bed rails, determine if the bed rail was a personal assistive services device (PASD) or a restraint and whether the bed was "tested for entrapment". The policy did not include any direction for staff to determine what clinical health conditions, sleep patterns, habits or behaviours would be monitored for while residents were asleep, for how long and which conditions, patterns, habits and behaviours were considered a risk factor for bed related injuries, suspension risks and entrapment risks when bed rails were applied. The risk related portion of the assessment

included whether the bed system either passed or failed any zones of entrapment. The policy did not include the need to re-assess the resident if a change to the bed system was made or a different bed system was provided or if the resident's condition, behaviour or patterns of sleep changed. The policy only included that "if any part of the bed system changed (mattress, bed frame), the system will be re-tested for that resident's use".

The BSA form did not include some important factors related to bed safety as identified in the Clinical Guidance document. The factors include but are not limited to the resident's cognition status, medication use, incontinence status, sleep characteristics or disorders (restlessness, position on mattress, sleep walking, vivid dreams etc), altered sensations, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely and any condition or behaviour that increases the resident's risk of becoming injured, entrapped or suspended from the bed or bed rail. The BSA did however include some relevant factors such as whether the resident fell from bed, acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail, attempted to climb over the bed rails, falls history, pain issues and mobility status. In order to answer these types of questions however, the newly admitted resident would need to be monitored by staff for a period of time while in bed, initially without the use of bed rails, then with the use of an alternative, followed by the use of bed rails.

PSWs identified that they were tasked to monitor all residents while in bed (with and without bed rails) post admission for bed mobility to determine if residents moved to and from lying position, turned side to side, the position of body while in bed and for "safety" while in bed which included ensuring that they were in bed and not on the floor, entrapped by their bed rails or found in a strange position. The time that the residents were observed was documented in the residents' electronic charts on a "daily flow sheet". Any safety issues were required to be brought forward to the registered nurse. The information acquired by the PSWs was conveyed to the registered staff to complete the BSA. The licensee's policy did not include this process or that PSWs were included in the bed system assessment.

The BSA form included an "alternatives" section that included some relevant alternatives, but most were interventions for managing falls. The examples included a call bell, bed alarm, floor mats, high/ low bed, timed/scheduled toileting, assistive devices within reach, restorative care referral, decreased time in bed and increased safety checks. According to the Clinical Guidance document, the use of

"perimeter reminders" or "border definers" such as body pillow, cushions, bolsters (soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various specific monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. Some of these particular accessories or modified equipment were not included as options on the BSA form or in the policy to better guide staff decision making. The selection of the alternatives would have to be very specific to the resident's assessed condition after an observation period without the use of bed rails.

1. Resident #100 was equipped with a bed system that included two half-length bed rails upon admission in 2011. The resident's bed safety assessments completed in December 2013, and March 2014, each included that the resident required two half-length bed rails for bed mobility and the safety assessment section was blank. The safety assessment section included relevant questions such as falls from bed, injuries acquired from bed rail use, limb entrapment or skin tears and bruising. The assessment dated July 2015, identified that the resident had a history of falls. The assessment dated July 2016, was partially incomplete and did not include any information about their mobility status, safety risks or alternatives used. Both the latter two assessments identified the use of two half-length bed rails for bed mobility and the 2016 assessment did not include that both bed rails were padded in July 2016.

The resident's written plan of care identified the use of two bed rails under four different focuses. The prevention of falls, bed mobility, pressure ulcer/skin and PASD bed rails focus areas each had similar goals and interventions. The resident was identified to require extensive assistance of two staff for bed mobility. In addition, the plan included the use of a high/low bed as of October 2016. The plan included that the resident had a medical condition that included involuntary body movements, was high risk of falls, had decreased cognition, had difficulties with communications, was resistive and was on medications. The resident's condition caused the resident to involuntarily shift in bed and as a result, both of the bed rails were padded in July 2016, "to minimize injury/safety when resident moved about in bed".

According to PSWs, the resident favoured one side and had involuntary body movements which required the resident to be frequently repositioned back to the centre of the bed. On a specified date in October 2016, the resident was found on the floor next to their bed, which was at the lowest level (height of a person's mid thigh), had the foot end of the bed elevated and the application of both half-length

bed rails which extended from the head board to the midway point of the bed. The post fall assessment completed on the same date by two RPNs and a PSW, did not include the need for any new or different interventions as a result of the fall. However, on the same date the resident was provided with a different bed system, one that could be lowered to the floor and had two shorter length bed rails. The bed rails were identified as “rotating assist bed rails”, which were noted to be approximately two feet long and could be rotated and locked into two different positions, a "guard" position (horizontal) or an "assist" position (vertical). The bed rails were located centrally along the length of the bed when in the “guard” position. The terms were derived from the manufacturer's user guide.

Post fall and during the month of October 2016, the resident continued to be found by PSWs on different shifts, in a position that placed them at risk of falling, however no falls to the floor were documented. Several PSWs reported that in order to prevent the resident from falling or involuntarily moving off the bed, the resident's bed was moved up against a wall within the bedroom. The PSWs were not able to remember when the change was implemented. The PSWs reported that they felt that the interventions were the best solution to solve the resident's bed mobility issues as the bed rail was too short and did not extend from the centre of the bed to the head board. The PSWs reported their concerns to the PSW co-ordinator and to registered staff about the bed's short bed rails and felt they were not effective at keeping the resident in bed. On a specified date in February 2017, a progress note made by an RPN identified that the resident was in a position that placed them at risk of falling off the bed. The RPN documented that they made a request to provide the resident with a “regular” bed instead of the high/low bed for their safety. The regular bed was confirmed to be the same bed the resident had prior to October 2016, which was a non-electrical bed that could not be lowered down below the level of the mid-thigh and had two half rails that could be raised or lowered. However, the resident was not provided the "regular" bed or their "old" bed as the Director of Care and members of the "falls prevention committee" felt that it was best the resident have a bed that could be lowered to the floor. The PSWs reported that some time in early February 2017, the resident's bed was moved away from the wall as the PSW co-ordinator received concerns from other PSWs, that they felt that the resident might receive an injury from the wall or become lodged between the wall and the bed frame, and the bed was moved away from the wall.

On a specified date in February 2017, the resident slid off the bed, between the head board and the rotating assist bed rail. The bed was in the lowest position (as

required in the plan of care) and the distance from the top of the resident's mattress to the floor was 15 inches. The resident was found on the floor during an hourly check by a PSW and was without vital signs. The resident was being treated for two separate medical conditions at the time. The cause of death was confirmed by a coroner to be related to the resident's medical condition. During the inspection, the home's maintenance person was in the resident's former room when the resident's bed was observed. It was confirmed to have two rotating assist rails on the frame. One bed rail was padded and another bed rail was noted to be bowed out and away from the frame. The gap between the edge of the mattress and the bed rail was large enough for the inspector to get their arm into the zone. The maintenance person had not received any maintenance requests from staff for the bed rail to be evaluated and agreed that it should not have such a large gap. The bed was unoccupied at the time and had not been assigned to a resident. The maintenance person stated that he would address the condition of the bed rail that day.

The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not. The resident was not re-assessed using the BSA form when they received a different bed in October 2016 and no alternatives were documented as trialled before the resident was provided with the rotating assist bed rails.

2. Resident #101 was observed at the time of inspection, lying on their bed with both half-length bed rails elevated. The resident's bed safety assessment was completed in January 2017, and included that the resident preferred to have both bed rails elevated when in bed and had a history of falling. The resident's mobility status was not completed by the assessor. The alternative trialled included a "call bell". The reason provided for the use of the bed rails included "for bed mobility and positioning assistance" and that the resident/ SDM was informed of the safety risks associated with the use of bed rails and consented to their use. The resident's written plan of care included that the resident was able to reposition themselves and move side to side with the use of the bed rails and that "staff may need to offer one to two person extensive assistance with moving up and into the bed if not centered". The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with

bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not.

3 . Resident #102 was observed at the time of inspection, lying on their bed with both half- length bed rails elevated. The resident's BSA was completed in December 2016, and included that the resident did not have a preference for bed rails, had a history of falling and was immobile. The interventions put in place included a bed alarm, call bell, timed toileting, increased safety checks (q1-2 hr) and concluded that two bed rails would be applied for bed mobility and that the resident/SDM was informed of the safety risks associated with the use of bed rails and consented to their use. The resident's written plan of care for bed mobility included "the use of a bed alarm to notify staff when resident attempts to get out of bed" and "both bed rails were to be engaged when in bed to assist with positioning as per POA wishes". The BSA and the written of plan of care were not consistent with respect to the resident's mobility status. The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not.

4. Resident #103 was not observed in bed at the time of inspection, however their bed was observed with two rotating assist rails attached to the bed frame in the "assist" position. According to the resident's last BSA dated January 2016, the resident could not state their preference for bed rail use, had a history of falling, a history of falling from bed and trying to get out of bed with rails in place, received an injury from a bed rail, and previously had a body part caught in the bed rail. As a result, a different bed was provided that was equipped with rotating assist bed rails. Despite the risk factors for further bed rail injury and entrapment, the assessor concluded that the resident required one side rail for bed mobility and repositioning assistance. The resident's written plan of care included that they needed "extensive assistance of two persons with bed mobility at times when tired, staff may place two bed rails in upright position for the resident to move in bed". The PSW reported that the resident slept with both of the bed rails in the "guard" position. No re-assessment was conducted of the resident when they received a different bed system. During the inspection, the right bed rail was noted to be quite unstable and loose and was reported to an RN. The staff were not aware of the bed rail condition and did not identify the issue which further increased the

resident's risk of entrapment or injury. The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not.

The conclusions related to these residents and the use of their bed rails was not comprehensive, was not based on all of the factors provided in the Clinical Guidance document and lacked sufficient documentation in making a comparison between the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident. [s. 15. (1) (a)]

Additional Required Actions:

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

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee did not ensure that resident #100 was reassessed and the plan of care reviewed and revised when care set out in the plan was not effective.

Resident #100 was admitted to the home in January 2011 and passed away in February 2017. The resident was diagnosed with a specific medical condition and as required, a written plan of care was developed and identified that the resident had a specific medical condition, which included a series of associated symptoms including involuntary body movements. As such, the resident required interventions to manage their condition with all aspects of daily living. The plan included several different focus areas such as "Bed Mobility", "Falls" and "PASD Bed Rails" and listed interventions for the personal support workers (PSWs) to follow in order to manage the resident's condition. However, according to the PSWs interviewed, the plan of care did not include effective strategies or alternative interventions to manage the resident's involuntary body movements while in bed over a period of several months in 2016.

According to clinical records documented by registered nurses (RN), registered practical nurses (RPN) and statements made by several PSWs, the resident favoured one side and had involuntary body movements which required the resident to be frequently repositioned back to the centre of the bed. On a specified date in October 2016, the resident was found on the floor next to their bed. No falls arrest mattress was provided or included in the plan of care. The post fall assessment completed on the same date by two RPNs and a PSW, did not include the need for any new or different interventions as a result of the fall. However, on the same date, the resident was provided with a different bed system, one that could be lowered completely to the floor and had two shorter length bed rails, which were located centrally along the length of the bed when in the "guard" position and could not be lowered. The bed rails were identified as “rotating assist bed rails”, which were noted to be approximately two feet long and could be rotated and locked into two different positions, a "guard" position (horizontal) or an "assist" position (vertical).

Post fall and during the month of October 2016, the resident continued to be found by PSWs on different shifts, in a position that placed them at risk of falling, however no falls to the floor were documented. Several PSWs reported that in order to prevent the resident from falling or involuntarily moving off the bed, the resident's

bed was moved up against a wall within the bedroom. The PSWs were not able to remember when the change was implemented. The PSWs reported that they felt that the interventions were the best solution to solve the resident's involuntary bed mobility issues as the bed rail was too short and did not extend from the centre of the bed to the head board. The PSWs reported their concerns to the PSW co-ordinator and to registered staff about the bed's short bed rails and felt they were not effective at keeping the resident in bed. On a specified date in February 2017, a progress note was made by an RPN that identified that the resident was in a position that placed them at risk of falling off the bed. The RPN documented that they made a request to provide the resident with a "regular" bed instead of the high/low bed for their safety. The "regular" bed was confirmed to be the same bed the resident had prior to October 2016, which was a non-electrical bed that could not be lowered down below the level of the mid-thigh and had two half length rails that could be raised or lowered. However, the resident was not provided the "regular" bed or their "old" bed as the Director of Care and members of the "falls prevention committee" felt that it was best the resident have a bed that could be lowered to the floor. The PSWs reported that some time in February 2017, the resident's bed was moved away from the wall as the PSW co-ordinator received concerns from other PSWs, that they felt that the resident might receive an injury from the wall or become lodged between the wall and the bed frame, and the bed was moved away from the wall.

On a specified date in February 2017, the resident slid off the bed between the head board and the rotating assist bed rail. The bed was in the lowest position (as required in the plan of care) and the distance from the top of the resident's mattress to the floor was 15 inches. The resident was found on the floor during an hourly check by a PSW and was without vital signs. The resident was being treated for two separate medical conditions at the time. The cause of death was confirmed by a coroner to be related to the resident's medical condition.

Under the "Bed Mobility" focus, an intervention dated 2013 included "two staff physical extensive assistance to turn resident side to side and to assist the resident to reach for the bed rails to hold on while staff complete routine care", and an intervention dated 2014 included "when resident is coming to a sitting position staff to cue resident to use the side rails to pull themselves to an upright position while staff are supporting their back and guiding them, staff to assist with swinging legs over side of bed". The interventions did not include how PSWs would manage the resident's bed safety risks.

Under the "PASD Bed Rails" focus, an intervention dated December 2013 included that "both bed rails are "engaged" in the (locked in up position so that the bed rail won't slip down while resident is in bed" and and intervention dated December 2013 and revised June 2015 that the "resident has two PASD bed rail, one staff has to assist them by cueing them to hold onto the bed rail while they are turning from side to side while in bed". These interventions were noted to be related to the resident's previous bed when they had two half rails. The intervention was also confusing as the bed rail itself was identified to have an issue of "slipping down" or perhaps not staying latched or locked. The interventions did not include any information about the type of bed rails the bed was equipped with when the resident received it in October 2016, or how the resident would benefit from using the bed rails while in bed without staff assistance. According to the interventions, the resident was not able to use the bed rails for turning or repositioning independently.

Under the "Falls" focus, an intervention dated October 2016, included that the resident was at "high risk of falls", "resident has a hi-low bed as they slid out of bed in October 2016" and "resident has padding for their bed rails to minimize injury/safety when they move about in bed", an intervention dated June 2014 to "resident has order for medication for a specified behaviour, monitor for side effect such as falls and document effect", an intervention dated July 2016, "resident has padding for their bed rails to minimize injury/safety when they move about in bed" and an intervention dated September 2013, "monitor resident every hour during the night for safety". A falls arrest mattress was not included as an intervention to minimize injury to the resident should they fall from bed (as the bed could not be completely lowered to the floor). The interventions were not re-evaluated to determine if the bed rails were effective at keeping the resident from falling from bed and if not, what other solutions could have been trialled. Solutions including but not limited to, removing the bed frame entirely and leaving the mattress on the floor or trialling bed accessories such as soft rails or bolsters to provide a perimeter around the bed, were not considered.

The plan of care included a focus related to a specific symptom and the resident was identified to be at risk of choking/coughing or aspiration. The interventions included prevention of choking strategies while the resident was eating, proper positioning, to keep upright for 30 minutes after each meal, specific food textures and not to speak while eating. However there was no information regarding the need to keep the resident's head elevated while in bed while sleeping. The PSWs acknowledged that they knew the resident was at risk and felt that keeping the bed

elevated at the head was safer for the resident.

The PSW's knowledge of the resident's sleep patterns, bed mobility and safety risks were well known and the care set out in the plan was not effective as identified in the above noted focus areas. The resident was not re-assessed when they received a different bed system and the plan of care was not revised with the various strategies and interventions that were being implemented in late 2016 and early 2017. [s. 6. (10) (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 to ensure that all residents are re-assessed and the plan of care reviewed and revised when care set out in the plan is not effective, to be implemented voluntarily.

Issued on this 11 day of August 2017 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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Amended Public Copy/Copie modifiée du public de permis

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

Inspection No. / No de l'inspection : 2017_539120_0016 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / Registre no. : 004648-17 (A1)

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

Report Date(s) / Date(s) du Rapport : Aug 11, 2017;(A1)

Licensee / Titulaire de permis :
Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

LTC Home / Foyer de SLD :
Chartwell Willowgrove Long Term Care Residence
1217 Old Mohawk Road, ANCASTER, ON, L9K-1P6

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

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Natasha Murray

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To Regency LTC Operating Limited Partnership on behalf of Regency Operator GP Inc. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1. Resident #103 shall be re-assessed immediately in accordance with the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) to determine if their bed rail is required while in bed unsupervised, and if so, if their bed rail type presents any safety risks to the resident while in bed. Any safety risks identified shall be mitigated or interventions implemented to reduce the safety risks.

2. Immediately evaluate all of the beds in the home that are equipped with rotating assist bed rails for fit and function. Bed rails must not be loose or

bowed out and away from the bed frame. All such bed rails are to be replaced or repaired. The work shall be documented and any beds that receive a different or new bed rail must be re-evaluated using the entrapment tool as identified in the "Health Canada guidance document “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006”.

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

a. the resident while sleeping for a specified period of time, to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and
b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during an observation period; and
c. the resident while sleeping for a specific period of time, to establish safety risks to the resident after a bed rail has been applied and deemed necessary where an alternative was not successful; and

4. All registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply the expectations identified in both the “Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards, 2006” and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings” (U.S. F.D.A, April 2003) in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

5. An interdisciplinary team shall assess all residents who use one or more

bed rails using the amended bed safety assessment form(s) and document the assessed results and recommendations for each resident.

6. Update the written plan of care for those residents where changes were identified after re-assessing each resident using the amended bed safety assessment form(s). Include in the written plan of care any necessary interventions that are required to mitigate any identified bed safety hazards.

7. Amend the existing policy tilted "Bed System Assessment" (LTC-CA-ON-200-07-22) dated January 2016, related to the use of bed rails by residents so that it will guide an assessor in completing resident clinical assessments in accordance with the U.S. F.D.A's document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings".

8. Develop and implement a bed safety training program for all direct care staff and housekeepers. The training program shall include a component that is face to face and that deals with the risks associated with the use of bed rails, the seven zones of entrapment, how beds are evaluated (using the measuring tool), how to recognize when a bed system is unsafe, how and when to report bed safety concerns and how to mitigate any entrapment zones if necessary.

Grounds / Motifs :

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

On August 21, 2012, a notice was issued to the Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was "expected to be used as the best practice document in LTC Homes". The HC Guidelines includes the titles of two additional companion documents developed by the Food and Drug Administration (FDA) in the United States and suggests that the documents are "useful resources".

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used. 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, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/Substitute Decision Maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting habits, sleeping patterns or habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail. The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

For this inspection, four residents (#100-103) were selected for review to determine whether they were assessed for bed rail safety in accordance with the Clinical Guidance document and if any safety risks were identified and mitigated.

According to the licensee's "Bed System Assessment" (LTC-CA-ON-200-07-22) policy dated January 2016, and confirmed by several registered practical nurses and several personal support workers (PSWs), residents who were newly admitted were not required to be observed while sleeping for a period of time with and without bed

rails. The policy directed registered staff to complete a form titled "Bed System Assessment" (BSA) "before the resident was put to bed for their first night", discuss the risks associated with bed rails, if at the conclusion the bed rails were to be used, the nurse would instruct the resident on the use of the bed rails, determine if the bed rail was a personal assistive services device (PASD) or a restraint and whether the bed was "tested for entrapment". The policy did not include any direction for staff to determine what clinical health conditions, sleep patterns, habits or behaviours would be monitored for while residents were asleep, for how long and which conditions, patterns, habits and behaviours were considered a risk factor for bed related injuries, suspension risks and entrapment risks when bed rails were applied. The risk related portion of the assessment included whether the bed system either passed or failed any zones of entrapment. The policy did not include the need to re-assess the resident if a change to the bed system was made or a different bed system was provided or if the resident's condition, behaviour or patterns of sleep changed. The policy only included that "if any part of the bed system changed (mattress, bed frame), the system will be re-tested for that resident's use".

The BSA form did not include some important factors related to bed safety as identified in the Clinical Guidance document. The factors include but are not limited to the resident's cognition status, medication use, incontinence status, sleep characteristics or disorders (restlessness, position on mattress, sleep walking, vivid dreams etc), altered sensations, involuntary movements, communication disabilities, whether they were able to operate the bed rails safely and any condition or behaviour that increases the resident's risk of becoming injured, entrapped or suspended from the bed or bed rail. The BSA did however include some relevant factors such as whether the resident fell from bed, acquired any injuries from the bed rail, got their arms or legs caught through the openings in the bed rail, attempted to climb over the bed rails, falls history, pain issues and mobility status. In order to answer these types of questions however, the newly admitted resident would need to be monitored by staff for a period of time while in bed, initially without the use of bed rails, then with the use of an alternative, followed by the use of bed rails.

PSWs identified that they were tasked to monitor all residents while in bed (with and without bed rails) post admission for bed mobility to determine if residents moved to and from lying position, turned side to side, the position of body while in bed and for "safety" while in bed which included ensuring that they were in bed and not on the floor, entrapped by their bed rails or found in a strange position. The time that the residents were observed was documented in the residents' electronic charts on a

"daily flow sheet". Any safety issues were required to be brought forward to the registered nurse. The information acquired by the PSWs was conveyed to the registered staff to complete the BSA. The licensee's policy did not include this process or that PSWs were included in the bed system assessment.

The BSA form included an "alternatives" section that included some relevant alternatives, but most were interventions for managing falls. The examples included a call bell, bed alarm, floor mats, high/ low bed, timed/scheduled toileting, assistive devices within reach, restorative care referral, decreased time in bed and increased safety checks. According to the Clinical Guidance document, the use of "perimeter reminders" or "border definers" such as body pillow, cushions, bolsters(soft rails), mattresses with lipped/raised edges, bed alarms, hand grips and various specific monitoring strategies and distractions (related to toileting, pain, insomnia, repositioning, comfort) were identified as potential alternatives. Some of these particular accessories or modified equipment were not included as options on the BSA form or in the policy to better guide staff decision making. The selection of the alternatives would have to be very specific to the resident's assessed condition after an observation period without the use of bed rails.

1. Resident #100 was equipped with a bed system that included two half-length bed rails upon admission in 2011. The resident's bed safety assessments completed in December 2013, and March 2014, each included that the resident required two half-length bed rails for bed mobility and the safety assessment section was blank. The safety assessment section included relevant questions such as falls from bed, injuries acquired from bed rail use, limb entrapment or skin tears and bruising. The assessment dated July 2015, identified that the resident had a history of falls. The assessment dated July 2016, was partially incomplete and did not include any information about their mobility status, safety risks or alternatives used. Both the latter two assessments identified the use of two half-length bed rails for bed mobility and the 2016 assessment did not include that both bed rails were padded in July 2016.

The resident's written plan of care identified the use of two bed rails under four different focuses. The prevention of falls, bed mobility, pressure ulcer/skin and PASD bed rails focus areas each had similar goals and interventions. The resident was identified to require extensive assistance of two staff for bed mobility. In addition, the plan included the use of a high/low bed as of October 2016. The plan included that the resident had a medical condition that included involuntary body movements,

was high risk of falls, had decreased cognition, had difficulties with communications, was resistive and was on medications. The resident's condition caused the resident to involuntarily shift in bed and as a result, both of the bed rails were padded in July 2016, "to minimize injury/safety when resident moved about in bed".

According to PSWs, the resident favoured one side and had involuntary body movements which required the resident to be frequently repositioned back to the centre of the bed. On a specified date in October 2016, the resident was found on the floor next to their bed, which was at the lowest level (height of a person's mid thigh), had the foot end of the bed elevated and the application of both half-length bed rails which extended from the head board to the midway point of the bed. The post fall assessment completed on the same date by two RPNs and a PSW, did not include the need for any new or different interventions as a result of the fall. However, on the same date the resident was provided with a different bed system, one that could be lowered to the floor and had two shorter length bed rails. The bed rails were identified as "rotating assist bed rails", which were noted to be approximately two feet long and could be rotated and locked into two different positions, a "guard" position (horizontal) or an "assist" position (vertical). The bed rails were located centrally along the length of the bed when in the "guard" position. The terms were derived from the manufacturer's user guide.

Post fall and during the month of October 2016, the resident continued to be found by PSWs on different shifts, in a position that placed them at risk of falling, however no falls to the floor were documented. Several PSWs reported that in order to prevent the resident from falling or involuntarily moving off the bed, the resident's bed was moved up against a wall within the bedroom. The PSWs were not able to remember when the change was implemented. The PSWs reported that they felt that the interventions were the best solution to solve the resident's bed mobility issues as the bed rail was too short and did not extend from the centre of the bed to the head board. The PSWs reported their concerns to the PSW co-ordinator and to registered staff about the bed's short bed rails and felt they were not effective at keeping the resident in bed. On a specified date in February 2017, a progress note made by an RPN identified that the resident was in a position that placed them at risk of falling off the bed. The RPN documented that they made a request to provide the resident with a "regular" bed instead of the high/low bed for their safety. The regular bed was confirmed to be the same bed the resident had prior to October 2016, which was a non-electrical bed that could not be lowered down below the level of the mid-thigh and had two half rails that could be raised or lowered. However, the resident was not

provided the "regular" bed or their "old" bed as the Director of Care and members of the "falls prevention committee" felt that it was best the resident have a bed that could be lowered to the floor. The PSWs reported that some time in early February 2017, the resident's bed was moved away from the wall as the PSW co-ordinator received concerns from other PSWs, that they felt that the resident might receive an injury from the wall or become lodged between the wall and the bed frame, and the bed was moved away from the wall.

On a specified date in February 2017, the resident slid off the bed, between the head board and the rotating assist bed rail. The bed was in the lowest position (as required in the plan of care) and the distance from the top of the resident's mattress to the floor was 15 inches. The resident was found on the floor during an hourly check by a PSW and was without vital signs. The resident was being treated for two separate medical conditions at the time. The cause of death was confirmed by a coroner to be related to the resident's medical condition. During the inspection, the home's maintenance person was in the resident's former room when the resident's bed was observed. It was confirmed to have two rotating assist rails on the frame. One bed rail was padded and another bed rail was noted to be bowed out and away from the frame. The gap between the edge of the mattress and the bed rail was large enough for the inspector to get their arm into the zone. The maintenance person had not received any maintenance requests from staff for the bed rail to be evaluated and agreed that it should not have such a large gap. The bed was unoccupied at the time and had not been assigned to a resident. The maintenance person stated that he would address the condition of the bed rail that day.

The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not. The resident was not re-assessed using the BSA form when they received a different bed in October 2016 and no alternatives were documented as trialled before the resident was provided with the rotating assist bed rails.

2. Resident #101 was observed at the time of inspection, lying on their bed with both half-length bed rails elevated. The resident's bed safety assessment was completed in January 2017, and included that the resident preferred to have both bed rails elevated when in bed and had a history of falling. The resident's mobility status was

not completed by the assessor. The alternative trialled included a "call bell". The reason provided for the use of the bed rails included "for bed mobility and positioning assistance" and that the resident/ SDM was informed of the safety risks associated with the use of bed rails and consented to their use. The resident's written plan of care included that the resident was able to reposition themselves and move side to side with the use of the bed rails and that "staff may need to offer one to two person extensive assistance with moving up and into the bed if not centered". The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not.

3 . Resident #102 was observed at the time of inspection, lying on their bed with both half- length bed rails elevated. The resident's BSA was completed in December 2016, and included that the resident did not have a preference for bed rails, had a history of falling and was immobile. The interventions put in place included a bed alarm, call bell, timed toileting, increased safety checks (q1-2 hr) and concluded that two bed rails would be applied for bed mobility and that the resident/SDM was informed of the safety risks associated with the use of bed rails and consented to their use. The resident's written plan of care for bed mobility included "the use of a bed alarm to notify staff when resident attempts to get out of bed" and "both bed rails were to be engaged when in bed to assist with positioning as per POA wishes". The BSA and the written of plan of care were not consistent with respect to the resident's mobility status. The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not.

4. Resident #103 was not observed in bed at the time of inspection, however their bed was observed with two rotating assist rails attached to the bed frame in the "assist" position. According to the resident's last BSA dated January 2016, the resident could not state their preference for bed rail use, had a history of falling, a history of falling from bed and trying to get out of bed with rails in place, received an injury from a bed rail, and previously had a body part caught in the bed rail. As a result, a different bed was provided that was equipped with rotating assist bed rails. Despite the risk factors for further bed rail injury and entrapment, the assessor

concluded that the resident required one side rail for bed mobility and repositioning assistance. The resident's written plan of care included that they needed "extensive assistance of two persons with bed mobility at times when tired, staff may place two bed rails in upright position for the resident to move in bed". The PSW reported that the resident slept with both of the bed rails in the "guard" position. No re-assessment was conducted of the resident when they received a different bed system. During the inspection, the right bed rail was noted to be quite unstable and loose and was reported to an RN. The staff were not aware of the bed rail condition and did not identify the issue which further increased the resident's risk of entrapment or injury. The assessment did not include a sleep observation process whereby the resident's sleep patterns, behaviours and habits were monitored and documented and whether risks were identified while the resident was in bed with bed rails applied. The assessment did not include what was trialled before the use of the hard bed rails, for how long and whether the alternative was successful or not.

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

This order is based upon three factors where there has been a finding of noncompliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include scope, severity and history of non-compliance. In relation to s. 15(1) of Ontario Regulation 79/10, the scope of the non-compliance is widespread, as none of the residents who used one or more bed rails were assessed in accordance with prevailing practices, the severity of the non-compliance has the potential to cause harm to residents related to bed safety concerns and there has been no history of non-compliance related to bed safety in the last three years.
(120)

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

Oct 31, 2017(A1)

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

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection 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

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection 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

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11 day of August 2017 (A1)

Signature of Inspector /
Signature de l'inspecteur :

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

Service Area Office /
Bureau régional de services : Hamilton