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
Feb 11, 2019	2018_619550_0015 (A1)	021717-18	Resident Quality Inspection

Licensee/Titulaire de permis

Corporation of the City of Cornwall
360 Pitt Street CORNWALL ON K6J 3P9

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

Glen-Stor-Dun Lodge
1900 Montreal Road CORNWALL ON K6H 7L1

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

Amended by RUZICA SUBOTIC-HOWELL (548) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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Amendment: Licensee requested due date extension to March 1, 2019 for Compliance Order (CO) #001.

Issued on this 11st day of February, 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

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

Ministère de la Santé et des Soins de longue durée

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Amended by RUZICA SUBOTIC-HOWELL (548) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): September 4, 5, 6, 7, 10, 11, 12, 13, 14 17 and 18, 2018.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care (DOC), the Manager of Nutritional Services (MNS), the Recreologist, the Staff Developer/Infection Control Officer, the Supervisor of Resident Services, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), several housekeeping staffs, a maintenance person, the President of the Residents' council, several family members and several residents.

In addition, the inspectors reviewed resident health care records, policies related to restraints, abuse and resident council minutes. Inspectors observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Dignity, Choice and Privacy
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home
Skin and Wound Care
Snack Observation
Sufficient Staffing

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19.	CO #001	2018_617148_0012	547
LTCHA, 2007 S.O. 2007, c.8 s. 8. (3)	CO #001	2018_617148_0011	550

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, residents were assessed and the bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and that steps are taken to prevent resident entrapment, taking into consideration all potential zone of entrapment.

Residents #006, #016 and #026 were observed over the course of the inspection to have bed rails in use. The following is a summary of the health care record review, observations and staff interviews related to the use of bed rails:

Resident #006's bed was observed by inspector #550 to have one rotating assist rail on each side of the bed; one in the guard position on the window side and one in the assist position on the door side. There was a pictogram on the wall next to resident's bed which indicated left bed rail was used. During an interview, RPN #102 indicated resident #006 required a quarter rail on one side and an assist rail on the other side as the resident uses those to hold on to when sitting up in bed. The bed rail assessment form in the resident's health care records was completed by RPN #131 and dated on a specific date. It was documented in section 2 and 3 on the assessment form that the resident did not qualify for bed rail use and to ensure that the resident's plan of care reflected this information. The inspector reviewed the resident's current plan of care and noted it was documented to put one side rail (right) in place when resting/sleeping to define bed parameters and provide feeling of comfort and security. There was no documentation indicating the potential risk for entrapment as the resident did not qualify for bed rail use.

Resident #016's bed was observed by inspector #550 to have one rotating assist rail on each side of the bed; one on the door side in the assist position and one on the wall side in the guard position. RPN #132 told the inspector during an interview that this resident has bed rails to assist them with bed mobility and transfers. They were installed at the resident and a family member's request. The bed rail assessment form in the resident's health care records was completed by RPN #133 and dated on a specific date. It was documented in section 3 on the assessment form that the resident did not qualify for bed rail use and to ensure that the resident's plan of care reflected this information. The inspector reviewed the resident's current plan of care and noted it was documented to put two side rails in place when resting/sleeping as per resident's request. There was no documentation indicating the potential risk for entrapment as the resident did not qualify for bed rail use.

Resident #026: the bed in this resident's room was observed by inspector #550 to have one rotary assist rail on each side of the bed. The rail on the right side of the bed was in the guard position and the one on the left side of the bed was in the assist position. The bed rail assessment for in the resident's health care records was completed by RPN #131 on a specific date. It was documented in section 2 and 3 on the assessment form that the resident did not qualify for bed rail use and to ensure that the resident's plan of care reflected this information. The inspector reviewed the resident's current plan of care and noted documented to put two side rails in place when resting/sleeping. There was no documentation indicating the potential risk for entrapment as the resident did not qualify for bed rail use.

During an interview, DOC #102 told the inspector that when bed rails are used for a resident who as per the bed rail assessment does not qualify for the use of bed rails, the registered nursing staff has to follow the directions on the bed rail assessment form and ensure their plan of care is reflected as such.

The inspector interviewed maintenance person #103 who indicated having conducted an evaluation of all the bed systems in the home in April and July 2018 with the assistance of maintenance person #134. They said that an evaluation of all the bed systems is completed once per year and they are not re-assessed after modifications are made to an existing bed system. Maintenance person #103 told inspector #550 having been trained on how to perform bed system evaluations by a technician from Cardinal Health Care and having referenced to the Health Canada guidance document "Adult Hospital Beds: Patient entrapment Hazards, Side Rail Latching Reliability and Other Hazards". The inspector reviewed the entrapment inspection report which was the document used to document the bed system evaluations. The inspector noted that the type of rails and any other type of equipment that was on each bed at the time the evaluation was conducted was not documented on the inspection report. The bed in room #2012, #2040-1 and #4016 were equipped with rotating assist rails. The assist rails have three positions. The guard (down) position: this position is intended to prevent an individual from inadvertently rolling out of bed, the assist (Up) position: assists the user in standing or sitting on bed and the transfer (Back) position: allows unimpeded access to user. There was no documentation to indicate that the rotating assist rails were evaluated in the three different positions. Maintenance person #103 told the inspector that they had forgotten to document the type of rails that were on the bed system when they did the evaluation and that each bed was evaluated with the equipment that was on the bed at the time

of the evaluation. After the bed system evaluation was completed, some modifications were made to some existing bed systems ie: mattresses were changed, but this was not documented and they did not remember which bed systems were modified. An evaluation of the new bed systems was not completed after the mattresses were changed. It was documented on the entrapment inspection report that the bed in room #2012, #2040-1 and #4016 had passed zone 5. Zone 5 refers to split bed rails and none of these beds were observed equipped with split bed rails. It was documented that the bed in room #2009 was evaluated for entrapment zone 1 to 7 and had passed. The bed system in room #2009 did not have any bed rails when it was observed by the inspector. It was documented that on July 30, 2018 when the bed system evaluation was completed in room #2040-1, this room was equipped with bed #001 and mattress #014. Upon observation by the inspector, this room was equipped with bed #108 and mattress #80.

The Administrator told the inspector they were not aware that the rotating assist rails required to be evaluated for zone 2, 3 and 4 in all three positions and they did not have the manufacturer's instruction manual for these types of rails. [s. 15. (1)]

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.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (2) The policy must comply with such requirements as may be provided for in the regulations. 2007, c. 8, s. 29 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the policy to minimize restraining of residents must comply with such requirements as may be provided for in the regulations.

As per O.Reg. 79/10, s.110. (7) every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Through multiple observations, a review of resident #006's health care records and documentation with staff, it was determined that resident #006 required the application of a seat belt restraint when seated in a wheelchair to prevent the resident from falling. RN# 127 and DOC #102 told inspector #550 that the PSWs document the restraining care on the restraint observation record. During a review of the restraint observation record for resident #006 for the month of August 2018, the inspector noted that the time of application of the seat belt, the resident's response to the restraining, the release of the device and all repositioning and the removal of the device were not always documented as identified in WN #5.

The inspector reviewed the home's Least Restraint Policy, #DM3-0501-80, with a review date of February 2017. It was observed by the inspector that the policy did not include the requirement for documentation of the person who applied the device, the monitoring, every release of the device, the removal and the time of removal.

The inspector reviewed the home's restraint policy with DOC #103. The DOC confirmed the above requirements were missing in their policy and added they would review the policy to ensure this is added. [s. 29. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the licensee's minimizing of restraint policy complies with the requirements in O. Reg. s. 110. (7), to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the planned menu items are offered and available at each meal and snack.

During an interview, a family member of resident #003 told inspector #550 that the resident preferred to have a cup of tea at snack time instead of juice but this was not offered to the resident as it was not available.

The inspector reviewed the regular week at a glance, spring/summer menu, week 3 and noted it was indicated for a.m. snack on that specific day: cranberry cocktail. There was a note at the bottom of the menu indicating menu snack notes: 1.25ml milk is offered every day at every snack. 180ml coffee or tea are offered every day at every snack. Minimum 125ml water is offered at every snack. Inspector #550 then observed the snack distribution at 1000hrs on Dundas unit. The inspector observed there was a pitcher of red juice and a pitcher of water on the snack cart. There was no milk, no tea and no coffee available. The residents

were offered a choice between a glass of cranberry juice and a glass of water. The residents were not offered milk, tea or coffee as per the menu.

On September 17, 2018, inspector #550 noted on the week at a glance menu it was indicated white grape cocktail for a.m. snack. The inspector observed PSW #119 distributing the a.m. snack to the residents on Dundas unit. There was a pitcher of orange coloured juice on the cart, but there was no milk, no tea and no coffee available. PSW #119 was interviewed by the inspector and indicated the juice was orange juice adding they never had white grape cocktail juice for the residents. PSW #119 told the inspector that the snack cart is prepared by the dietary aid and is left in the hallway outside of the servery. When it is time to distribute the snacks, the PSW gets the cart and has to go get the juice in the small refrigerator in the dining room. The PSW further added that water is not distributed to the residents in the morning and that milk, tea and coffee were not available at snack time as well. PSWs do not have access to the servery when the dietary aid is not there adding they were not there at snack time. The inspector observed that there was no one in the servery at that time, the lights were turned off and both doors were locked and not accessible. The inspector then went to the dining room refrigerator and observed inside the refrigerator a pitcher of light yellow colored juice, two pitchers of water and one pitcher filled to the quarter with milk.

Inspector went to the 4th floor, Seaway unit. The distribution of the a.m. snack was already finished and the cart had been returned to the dining room. The inspector observed there was a pitcher on the cart with 1/8th filled with light yellow colored juice and a note taped to the pitcher indicated white grape juice and was dated September 17. PSW #129 and #128 indicated to inspector they had distributed the a.m. snack to the residents. The indicated this morning residents were offered and provided with water and white grape juice. Milk, coffee and tea are not offered and not available at snack time. Inspector observed the small refrigerator in the dining room on this unit and noted there was no milk available and there was no tea or coffee available either. There was no staff in the servery and the door was locked. Both PSWs indicated they do not have access to the server when there are no staff inside.

The inspector observed the lunch meal service on Dundas unit on two separate days. Whole wheat bread and margarine was indicated as part of the menu on both days as per the week at a glance menu. There was also a note at the bottom of the menu indicating that whole wheat bread is offered every day at

Lunch and Dinner. The inspector observed that none of the residents were offered bread and margarine on both days. On the second observation of the lunch meal service, the inspector observed that resident # 026 was not offered meal choices. PSW #125 was provided with a plate with pureed food items by PSW#126 to feed to resident #026. The resident asked the PSW what the food was and PSW#125 indicated they did not know. Once the resident was done eating their main meal, PSW #126 brought a pureed cake to PSW#125 to feed the resident. Inspector interviewed PSW #126 who told the inspector that resident #026 was not able to make choices regarding food items. The PSW then proceeded to ask the resident if they wanted to have banana cake or mandarins for desert and the resident immediately replied they wanted to have the banana cake.

Inspector #550 interviewed the Manager of Nutritional Services (MNS) #115. The MNS told the inspector that the ability of a resident to make decisions regarding food choices can change from a meal to another. PSWs are to present both visual meal choices with a verbal explanation of the choices to all residents at every meal. When the resident is not able to say what they want to eat at that time and is not providing any non-verbal cues, the PSW is to inform the dietary aid (DA) that this resident was not able to choose what they wanted to eat. The DA will then verify the kardex at point of service for likes, dislikes, allergies, intolerance and will serve the resident according to this. MNS told the inspector the residents are to be offered whole wheat bread and margarine at every lunch and dinner and this is available in the cupboards in the dining room. The bread is to be put on the cart with the fluids and offered at the same time as the fluids to the residents. At snack time, the PSWs are to look at the menu to determine what the juice of the day is and then go to the refrigerator in the dining room to get a pitcher with the juice of the day, a pitcher of water and a pitcher of milk and add these items to the snack cart. The DA should have already put a pot of coffee and a pot of tea on the snack cart. [s. 71. (4)]

2. Inspector #550 observed the lunch meal service for Dundas unit on September 14, 2018. The planned menu for this meal as indicated on the week at a glance menu, week 3 was a choice of grilled fish with peppers, herbed oven roasted potatoes, orange basil mixed vegetables and iced banana cake or pancakes with maple syrup, blueberry sauce, pea meal bacon, baked beans and unsweetened mandarin orange sections. Whole wheat bread and margarine was also an item on the menu.

Inspector #550 observed that PSW #126 who was responsible for the meal distribution that day, served a food plate to PSW #125 to feed to resident #026. The plate contained pancakes, blueberry sauce, baked beans and pea meal bacon in a pureed texture. PSW fed the food items to the resident which the resident consumed. The resident was not provided with both menu choices for their main course and not offered bread and margarine. PSW #126 served a bowl which contained banana cake in a pureed texture to PSW #125 to feed to resident #026 after the main course was completed. Again the resident was not provided with a choice desert. During an interview, PSW #126 told inspector #550 that resident #026 was not able to make decisions regarding food choices. The PSW then turned to resident #026 and asked the resident if they wanted to have cake or mandarins for desert. The resident immediately replied they wanted to have the cake.

The Manager of Nutritional Services (MNS) #115 told the inspector during an interview all residents are to be offered the planned menu items indicated on the menu at each meal including bread and margarine at lunch and dinner. Because a resident's ability to make food choices can change from a meal to another, the PSWs have to explain what the choices are and show each resident two plates; one containing the first choice and another containing the second choice. If the resident is not able to make a decision after being presented with both choices, and the PSW was not able to identify any non-verbal cues to indicate a choice, the PSW will then to give the name of the resident they are serving to the dietary aid. The dietary aid will prepare a plate for the resident according to the documentation of the resident's likes, dislikes and allergies documented on the kardex at point of service.

As evidenced, the licensee failed to ensure that the planned menu items were offered and available at each meal and snack. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the planned menu items are offered and available at each meal and snack, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The Licensee of a Long-Term Care home has failed to ensure that the Director is informed of an incident in the home of missing or unaccounted for controlled substance, no later than one business day after the occurrence of the incident.

The Director of Care provided inspector #547 a copy of the medication incidents that occurred in the home for a period of three specific months inclusively. A medication incident was identified on a specified date regarding missing or unaccounted controlled substance of a specified controlled substance for resident #007.

On September 18, 2018 the Director of Care indicated not having submitted any critical incident to the Director regarding this incident of missing or unaccounted controlled substance as required. [s. 107. (3) 3.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the Director is informed of incidents in the home of missing or unaccounted for controlled substance, no later than one business day after the occurrence of the incident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
1. The circumstances precipitating the application of the physical device. O. Reg. 79/10, s. 110 (7).
2. What alternatives were considered and why those alternatives were inappropriate. O. Reg. 79/10, s. 110 (7).
3. The person who made the order, what device was ordered, and any instructions relating to the order. O. Reg. 79/10, s. 110 (7).
4. Consent. O. Reg. 79/10, s. 110 (7).
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure the resident's condition was reassessed and the effectiveness of the restraining evaluated by a physician or a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time based on the resident's condition or circumstances.

Resident #006 was observed by inspector #550 on two separate dates and time

seated in a wheelchair with a four point seat belt applied.

During an interview, RPN #101 indicated to the inspector that the registered nursing staff reassess the resident's condition and they evaluate the effectiveness of the restraining every eight hours. They initial the resident's restraint flow sheet to indicate this was completed.

The inspector reviewed the restraint observation record for the month of August 2018. This record is also referred to as the restraint flow sheet by staff. The inspector noted the RN/RPN initials column was not initialed on the following shifts for a specified month:

Night shift: eleven specified day
Day shift: five specified day
Evening shift: one specified day

Inspector #550 reviewed the restraint observation record for resident #006 with DOC #102. The DOC told the inspector that registered nursing staff are to reassess the resident and the effectiveness of the restraining every eight hour and initial the Restraint Observation Record as per their policy. Because the registered staff did not initial the restraint observation record on the shifts indicated above, there was no way of verifying that registered staff reassessed the resident and the effectiveness of the restraining was completed for those eight hours shifts. [s. 110. (2) 6.]

2. The licensee failed to ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application.
6. All assessment, reassessment and monitoring, including the resident's response.
7. Every release of the device and all repositioning.
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care.

Resident #006 was observed by inspector #550 on two separate dates and time seated in a wheelchair with a four point seat belt applied. A review of the resident's health care records and interviews with staffs indicated this resident

required the application of a seat belt restraint when seated in the wheelchair to prevent the resident from falling.

RN# 127 told the inspector the PSWs document the restraint care on the restraint observation record. The inspector reviewed the restraint observation record for resident #006 for a specified month. It was observed that:
-the time of application of the seat belt was not documented on eleven specified days,
-the resident's response was not documented on six specified day and shift,
-the release of the device and all repositioning on two specified day, and
-the removal of the device, including time of removal and the post-restraining care on four specified day.

The form was left blank on four specified day for a specified period of time.

The inspector reviewed the above documentation with DOC #102. The DOC confirmed the PSWs have to document the restraint care on the restraint observation record form and that the above documentation was missing for the specified month for resident #006. [s. 110. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident's condition is reassessed and the effectiveness of the restraining is evaluated by a member of a registered nursing staff at least every eight hours and that all assessment, reassessment and monitoring, including the resident's response, every release of the device and all repositioning, and the removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care are documented, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has specifically failed to ensure that that drugs are stored in an area that is used exclusively for drugs and drug-related supplies and that is secure and locked.

During the initial tour of the home on September 4 and during a subsequent observation on September 5, inspector #550 observed prescribed medicated creams and shampoos stored in a closet in the tub and shower room on the 2nd floor, Cornwall unit.

During an interview, PSW #100 indicated to the inspector that medicated shampoos and creams are kept in the closet in the tub and shower room during the summer months because they do not have their regular staff on and they may forget to apply them. The medicated creams and shampoos are returned to the medication room in the fall. PSW indicated that it is mostly prescribed shampoos they keep in there.

During an interview, RPN #101 told the inspector that the medicated creams and shampoos are to be kept locked in the medication room and not in the closet in the tub and shower room as this closet is used to store the cleaning products and the linen. Staffs are to return the creams and shampoos to the nurse after they

have been applied.

The Director of Care #102 confirmed to inspector #550 that all medicated creams and shampoos have to be stored in the medication room. [s. 129. (1) (a)]

2. On September 12, 2018 inspector #547 observed prescribed creams and ointments for the residents on the St-Lawrence wing of the fourth floor inside a plastic container in the resident hallway at 0715 hours. Inside this plastic container, inspector #547 observed at least ten bags that contained different prescribed creams or ointments with resident labels on them. This container was located on the top of a linen trolley situated outside the activity room that was unattended by any nursing staff members. Personal Support Worker (PSW) #107 was observed placing a plastic bag that contained resident #024's prescribed creams inside this plastic container on the linen trolley at 0722 hours. PSW #107 indicated this container was where the PSW's stored the wings prescribed creams and ointments for residents during personal care.

PSW #108 indicated to inspector #547 that the plastic container is left on the top of the wing linen carts during personal care and usually covered with a sheet. PSW #108 indicated that there was no direction that these prescribed creams are to be locked at all times, and that this has been the process in the home for a long time. PSW #108 indicated that once the personal care is completed, they will place the plastic container of prescribed creams and ointments inside the ice machine room, near the wing dining room.

As such, the medicated creams, ointments and shampoos used for residents were not stored in an area that is used exclusively for drugs and drug-related supplies and that was secured and locked [s. 129. (1) (a)]

3. The licensee has failed to ensure that controlled substances are stored in a separate, double-locked stationary cupboard in the locked area.

On September 12, 2018 RPN #105 indicated to inspector #547 that the home has a specified controlled substance used for residents in the home on an as needed basis stored inside the medication room of the third floor. RN #111 indicated to inspector #547 that they store the controlled substances used for residents that are prescribed on an as needed basis inside a locked container stored inside the refrigerator of the medication room. RN #111 indicated that the refrigerator is not locked. RN #111 indicated that there were presently four bottles of controlled

medications for residents inside this locked container.

As such, controlled substances prescribed for residents in the home are not stored in a separate, double-locked stationary cupboard inside the locked third floor medication room as required by this section. [s. 129. (1) (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 drugs are stored in an area that is used exclusively for drugs and drug-related supplies and that it is secured and locked, and that controlled substances are stored in a separate, double-locked stationary cupboard in a locked area, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that all areas where drugs are stored are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator.

On September 12, 2018 PSW #108 indicated to inspector #547 that they store the plastic container that contains the units bags of medicated creams and ointments for residents inside a storage room when personal care is completed. PSW #108 indicated that on the fourth floor St-Lawrence unit, they place the plastic bin on the counter inside the ice machine room. PSW #108 indicated that PSWs have keys to access this storage room as it is kept locked and that other staffs also have a key for this space, such as dietary and housekeeping staffs.

Housekeeper #106 is the regular housekeeper for the fourth floor. This housekeeper indicated to the inspector while unlocking the ice machine storage room with a key, to have access to this space for cleaning. Housekeeper #106 indicated that the plastic storage container for medicated creams and ointments is always located on the counter in this room.

Inspector #547 observed housekeeper #124 inside the medication storage room on the fourth floor attempting to fix the paper towel dispenser. Housekeeper #124 indicated to have been let into this storage room by RPN #105 a few minutes earlier. RPN #105 indicated to inspector #547 to have let housekeeper #124 inside the medication storage room earlier although being aware that housekeeping staff are not to be left unattended inside the medication storage room.

Inspector #547 observed the unlocked cupboards inside the medication storage room that contained the government medication stock supply for the fourth floor, prescribed medications for residents as overstock for the medication carts. The lower cupboards were also unlocked and inside was a cardboard box half full of drugs that are to be destroyed at a later date.

As such, the Licensee has not ensured that all areas where drugs are stored, are restricted to persons who may dispense, prescribe or administered drugs in the home as required by this section. [s. 130. 2.]

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 areas where drugs are stored, are restricted to persons who may dispense, prescribe or administer drugs in the home, and the Administrator, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction is:

(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and

(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider

On September 11, 2018 inspector #547 reviewed a list of the medication incidents and adverse drug reactions for the last quarter provided by the Director of Care. The following medication incidents reports were either not documented or reported as required as follows:

Medication incidents involving resident #022:

On a specified date, resident #022 was missing a controlled substance medication dispensed in a specific form. It was documented on this resident's Medication Administration Record (MAR) for a specific month to refer to the resident's progress notes for two specified dates.

A progress note for a specified date indicated that the resident's control substance was not found.

No medication incident involving resident #022 was documented for this specified date incident, together with any record of the immediate actions taken to assess and maintain the resident's health as required by subsection a. of this section.

No reporting of this incident to all required identified in subsection b. of this section.

Inspector #547 observed the resident's progress notes and medication incident report documented for another specified date incident whereby the controlled substance medication was not found. The medication incident report documented that the Director of Care was made aware, however this incident was not reported to the resident and or the resident's Substitute Decision Maker, the Pharmacy service provider and the attending physician as required by subsection b. of this

section.

Medication incident involving resident #007:

On a specified date RPN #121 documented an incident of a missing a tablet from resident #007 medication drug count of controlled substances at the beginning of the shift.

Inspector #547 reviewed the resident's MAR that documented the resident last received a controlled substance on a specified date at a specified time. The resident's progress notes indicated RPN #121 documented that resident #007 left for a leave of absence with their substitute decision maker (SDM) and charge RN provided the SDM the resident's medications and controlled substances prescribed to the resident for a specified period of time. Later that same shift, the resident's SDM called and informed the charge RN that the medications dispensed to the SDM were forgotten at the home before they left. The Charge RN located the medications dispensed to the resident in the resident's bathroom and returned them to the medication cart for storage. The medication count in the morning of a specified date indicated missing tablet of a controlled substance for resident #007.

The medication incident report documented this incident was reported to the Director of Care, however it was not reported to the resident and or the resident's SDM, the Pharmacy service provider and the physician as required by this section.

Medication incident involving resident #003:

On a specified date a medication incident report indicated resident #003 had two doses of a specific drug therapy remaining when the treatment should have been completed. Resident #003 was prescribed a specific drug therapy for a specified period of time and these two doses were omitted to be administered to resident #003.

This medication incident report indicated this incident was reported to the Director of Care, however was not reported to the resident and or the resident's SDM, the Pharmacy service provider and the physician as required. [s. 135. (1)]

2. The licensee has failed to ensure that a) all medication incidents and adverse

drug reactions are documented, reviewed and analyzed
b) corrective action is taken as necessary, and c) a written record is kept of everything required under clauses (a) and (b).

Medication incident report for resident #007 did not have a documented review or analysis of the medication incident or corrective actions taken as required by this section.

On September 18, 2018 the Director of Care indicated not having any further information or documentation into the analysis or corrective actions to this incident. [s. 135. (2)]

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 medication incidents involving a resident and every adverse drug reaction is documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and is reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. And all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

On a specified date a medication incident report was submitted to the Director of Care involving resident #003. Resident #003 was receiving a specific drug therapy for a specified period of time. This medication began on a specified date and was to have this treatment completed on another specified date. The medication incident report identified that there were two doses of this specific medication left in the resident's medication container.

Inspector #547 reviewed this medication incident with the Director of Care who indicated that the residents receive their prescribed medications from the Licensee's pharmacy, and that the number of tablets would have matched the number of doses required. The Director of Care reviewed the Medication Administration Records for resident #003 whereby all doses were documented as administered to the resident, and was unable to determine which doses were omitted.

As such, resident #003 did not receive the complete treatment of a specific medication as prescribed. [s. 131. (2)]

Issued on this 11st day of February, 2019 (A1)

[redacted]

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 RUZICA SUBOTIC-HOWELL (548) - (A1)
Inspection No. / No de l’inspection :	2018_619550_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021717-18 (A1)
Type of Inspection / Genre d’inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 11, 2019(A1)
Licensee / Titulaire de permis :	Corporation of the City of Cornwall 360 Pitt Street, CORNWALL, ON, K6J-3P9
LTC Home / Foyer de SLD :	Glen-Stor-Dun Lodge 1900 Montreal Road, CORNWALL, ON, K6H-7L1
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Norm Quenneville

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 Corporation of the City of Cornwall, 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

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 be compliant with O. Reg. s. 15. (1).

Specifically the Licensee shall:

1. Re-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, all
intermediate positions are to be evaluated. The zone specific test results are to be documented.
2. Maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident and which reflects the
most recent evaluation for each bed system. Ensure that a re-evaluation of a bed systems is completed as required, such as when a new bed system is created as a result of a change or replacement of components.
3. Review the plan of care of resident #006, #016, #026 and any other residents who are using bed rails to ensure that when a bed rail assessment demonstrated that the resident did not qualify for the use of bed rails, the resident's risk for entrapment is identified in the plan of care with specific interventions to mitigate those risks.
4. Develop and implement a documented ongoing auditing process to ensure that all requirements of this compliance order are satisfied.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that where bed rails were used, residents were assessed and the bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident and that steps are taken to prevent resident entrapment, taking into consideration all potential zone of entrapment.

Residents #006, #016 and #026 were observed over the course of the inspection to have bed rails in use. The following is a summary of the health care record review, observations and staff interviews related to the use of bed rails:

Resident #006's bed was observed by inspector #550 to have one rotating assist rail

on each side of the bed; one in the guard position on the window side and one in the assist position on the door side. There was a pictogram on the wall next to resident's bed which indicated left bed rail was used. During an interview, RPN #102 indicated resident #006 required a quarter rail on one side and an assist rail on the other side as the resident uses those to hold on to when sitting up in bed. The bed rail assessment form in the resident's health care records was completed by RPN #131 and dated on a specific date. It was documented in section 2 and 3 on the assessment form that the resident did not qualify for bed rail use and to ensure that the resident's plan of care reflected this information. The inspector reviewed the resident's current plan of care and noted it was documented to put one side rail (right) in place when resting/sleeping to define bed parameters and provide feeling of comfort and security. There was no documentation indicating the potential risk for entrapment as the resident did not qualify for bed rail use.

Resident #016's bed was observed by inspector #550 to have one rotating assist rail on each side of the bed; one on the door side in the assist position and one on the wall side in the guard position. RPN #132 told the inspector during an interview that this resident has bed rails to assist them with bed mobility and transfers. They were installed at the resident and a family member's request. The bed rail assessment form in the resident's health care records was completed by RPN #133 and dated on a specific date. It was documented in section 3 on the assessment form that the resident did not qualify for bed rail use and to ensure that the resident's plan of care reflected this information. The inspector reviewed the resident's current plan of care and noted it was documented to put two side rails in place when resting/sleeping as per resident's request. There was no documentation indicating the potential risk for entrapment as the resident did not qualify for bed rail use.

Resident #026: the bed in this resident's room was observed by inspector #550 to have one rotary assist rail on each side of the bed. The rail on the right side of the bed was in the guard position and the one on the left side of the bed was in the assist position. The bed rail assessment for in the resident's health care records was completed by RPN #131 on a specific date. It was documented in section 2 and 3 on the assessment form that the resident did not qualify for bed rail use and to ensure that the resident's plan of care reflected this information. The inspector reviewed the resident's current plan of care and noted documented to put two side rails in place when resting/sleeping. There was no documentation indicating the potential risk for entrapment as the resident did not qualify for bed rail use.

During an interview, DOC #102 told the inspector that when bed rails are used for a resident who as per the bed rail assessment does not qualify for the use of bed rails, the registered nursing staff has to follow the directions on the bed rail assessment form and ensure their plan of care is reflected as such.

The inspector interviewed maintenance person #103 who indicated having conducted an evaluation of all the bed systems in the home in April and July 2018 with the assistance of maintenance person #134. They said that an evaluation of all the bed systems is completed once per year and they are not re-assessed after modifications are made to an existing bed system. Maintenance person #103 told inspector #550 having been trained on how to perform bed system evaluations by a technician from Cardinal Health Care and having referenced to the Health Canada guidance document "Adult Hospital Beds: Patient entrapment Hazards, Side Rail Latching Reliability and Other Hazards". The inspector reviewed the entrapment inspection report which was the document used to document the bed system evaluations. The inspector noted that the type of rails and any other type of equipment that was on each bed at the time the evaluation was conducted was not documented on the inspection report. The bed in room #2012, #2040-1 and #4016 were equipped with rotating assist rails. The assist rails have three positions. The guard (down) position: this position is intended to prevent an individual from inadvertently rolling out of bed, the assist (Up) position: assists the user in standing or sitting on bed and the transfer (Back) position: allows unimpeded access to user. There was no documentation to indicate that the rotating assist rails were evaluated in the three different positions. Maintenance person #103 told the inspector that they had forgotten to document the type of rails that were on the bed system when they did the evaluation and that each bed was evaluated with the equipment that was on the bed at the time of the evaluation. After the bed system evaluation was completed, some modifications were made to some existing bed systems ie: mattresses were changed, but this was not documented and they did not remember which bed systems were modified. An evaluation of the new bed systems was not completed after the mattresses were changed. It was documented on the entrapment inspection report that the bed in room #2012, #2040-1 and #4016 had passed zone 5. Zone 5 refers to split bed rails and none of these beds were observed equipped with split bed rails. It was documented that the bed in room #2009 was evaluated for entrapment zone 1 to 7 and had passed. The bed system in room #2009 did not have any bed rails when it was observed by the inspector. It was documented that on

July 30, 2018 when the bed system evaluation was completed in room #2040-1, this room was equipped with bed #001 and mattress #014. Upon observation by the inspector, this room was equipped with bed #108 and mattress #80.

The Administrator told the inspector they were not aware that the rotating assist rails required to be evaluated for zone 2, 3 and 4 in all three positions and they did not have the manufacturer's instruction manual for these types of rails.

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents and the scope was widespread. A compliance order will be served to the licensee.
(550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 01, 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 11st day of February, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by RUZICA SUBOTIC-HOWELL (548) - (A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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