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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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 5, 2018	2018_539120_0043	026043-18	Critical Incident System

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

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

Linhaven
403 Ontario Street St. Catharines ON L2N 1L5

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

BERNADETTE SUSNIK (120)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 3, 2018

Critical Incident M551-000033-18 related to a bed system related injury with visit to hospital.

During the course of the inspection, the inspector(s) spoke with an associate director of care (ADOC), registered staff, personal support workers, housekeeper and housekeeping/laundry manager.

During the course of the inspection, the inspector toured an identified home area, observed several resident rooms and their bed systems, reviewed policies and procedures related bed safety and related resident clinical assessments and reviewed resident clinical records.

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

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

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(s)**

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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 AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
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. AMP (s) may be issued under section 156.1 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. AMP (s) may be issued under section 156.1 of the LTCHA

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 failed to ensure that, where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

The Director of the Ministry of Health and Long Term Care sent a memorandum to all long term care home administrators on August 12, 2012, identifying a specific document from Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards (2008)". The Director expected the administrators to follow the recommendations in the document to reduce or mitigate the risk of bed-related hazards. Included in the Health Canada guidelines, are the titles of two additional documents (companion guides) which further provide specific guidance in assessing residents who use one or more bed rails and how to mitigate bed systems that do not pass entrapment zone specifications. The companion guide for assessing residents is entitled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", and provides the necessary guidance in establishing a clinical assessment where bed rails are used by residents. The companion guide for mitigating bed systems is entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". The Health Canada Guidelines and the two companion guides are therefore the "prevailing practices" under s. 15(1) of O. Reg. 79/10 and shall be complied with.

In September 2018, resident #001 attempted to exit their bed unassisted. Interview with personal support worker (PSW) #101 revealed that they were alerted to the resident's room. When they arrived, the PSW realized that they required additional assistance and

RN #104 and RPN #105 responded to assist the resident. The resident sustained a bed system related injury and was transferred to hospital for further assessment and returned on the same date. Both bed rails were removed the day after the incident. The PSW reported that the resident had previously sustained a fall and that the resident often demonstrated a behaviour and had a specific level of care for bed mobility.

The resident's bed was observed at the time of inspection and no bed rails were attached to the frame. According to bed system test records obtained from the housekeeping manager, the resident's bed was measured for entrapment zones in and around the rails 20 days prior to the incident and the bed system passed.

According to the resident's written plan of care, last revised in August 2018, the resident was diagnosed with several risk factors associated with an increase in risk related to bed system related injury. The plan included that their bed was equipped with bed rails of a specific type which did not restrict movement. The intervention was listed under the focus for bed mobility along with the added intervention that the resident required assistance with transfers, assistance for bed mobility and specific positioning when sleeping. Under the focus for risk of falls, specific interventions were included and confirmed to have been in place. The plan of care for bed mobility status was not consistent with the information acquired from staff and the clinical notes. Positioning at the time of the incident was not documented within the clinical notes.

According to the resident's bed safety assessment, the resident was admitted in May 2018, and the assessment was completed on the same date. According to RN #102, who completed the assessment and was new to the position, the resident was identified to have at least one risk factor that placed them at higher risk of bed safety related injury when bed rails were applied. The RN stated that they did not know the resident's sleep habits or patterns while in bed over a period of time to determine what risks were prevalent. The RN documented under question #2a and #2b against the use of bed rails as the resident was able to complete some tasks. Yet, under question #3, the RN selected that the resident would use bed rails of a specific type. According to RN #102, they did not know that the specified type of bed rails were considered bed rails and they thought that bed system related injury only occurred with bed rails that were full length. In August 2018, the resident was re-assessed by a different RN (#106) who documented that bed rails of a specific type would be applied at the request of the resident. No documentation was made related to what bed rail alternatives were trialled before applying the bed rails and no documentation was made related to results from a sleep observation process to determine if any additional risks were present.

According to sleep related data collected by PSWs for resident #001 several weeks before and after the incident, the resident was in bed and sleeping for more than half of the the time. On other nights, the resident was documented to be either awake or out of bed. The majority of the observations were documented only once for the entire night, between 0400 and 0600 hours. No data was gathered to determine what type of risks needed to be observed while in bed. The questions included whether the resident slept through the night, was awake but in bed or was awake and out of bed. One day before the incident, a PSW documented that the resident was up and with staff twice during specific times. The same was documented on the date of the incident. The questions that the PSWs were required to answer were vague and not related directly to bed rail safety while in bed. According to the Clinical Guidelines, monitoring residents for specific behaviours while in bed, such as excessive bed movement, delirium, sleep related disorders, limbs through bed rails openings, playing with the bed rails, awareness of the bed rail and other activities would establish a better understanding of resident safety risks when bed rails are applied. These types of questions were discussed with the ADOC as more appropriate in deciding whether a bed rail would be appropriate and safe for the residents.

Two additional residents with the similar risk factors and whose beds were observed during the inspection to be equipped with two bed rails were reviewed during the inspection. Neither resident had a formal sleep assessment completed and did not have any bed rail alternatives trialled before having two bed rails applied to their beds. Although the residents were not in bed at the time of the inspection, both residents required bed rails according to their most recent plan of care and bed safety assessments.

According to resident #002's written plan of care, last revised in August 2018, the resident was diagnosed with several risk factors that placed them at higher risk of bed system related injury when bed rails were applied. The plan included that the resident's bed was equipped with specific type of bed rails which did not restrict movement. The intervention was listed under the focus for bed mobility along with the requirement for supervision. Under the focus for risk of falls, specific interventions were included.

Resident #002 was assessed for bed safety by an RN in November 2017 and again in August 2018, and the assessments included documentation that they had at least one risk factor that placed them at higher risk of bed system related injury when bed rails were applied. Neither assessment included questions related to other risk factors such

as medication use, pain, incontinence, sleep related disorders, behaviours, pain or falls risk. The assessment dated 2017, included that bed rails of a specific type would be used by the resident for bed mobility and a note that there were no concerns related to the use of the bed rails. Questions regarding what alternatives were trialled and what key factors for or against the use of the bed rails were not answered. The bed rail risk assessment completed in August 2018, which was a quarterly assessment, was revised and included questions related to sleep pattern and history. This particular question, along with key factors for or against bed rail use and alternatives considered or trialled were not answered. The questions that were not answered were essential in determining whether bed rails would be safe for the resident to use.

According to resident #003's written plan of care, last revised in August 2018, the resident was diagnosed with several risk factors that increased their risk of bed system related injury when bed rails were applied. The plan included that the resident's bed was equipped with bed rails of a particular type which did not restrict movement. The intervention was listed under the focus for bed mobility along with the added intervention that the resident required supervision. Under the focus for risk of falls, specific interventions were included.

Resident #003 was assessed for bed safety by an RN on admission in February 2018 and again in August 2018, as part of a quarterly assessment. Both assessments included documentation that the resident had at least three risk factors that placed them at higher risk of bed system related injury when bed rails were applied. No questions were listed related to risk factors such as medication use, pain, incontinence, sleep related disorders, behaviours or falls risk. The RN selected that bed rails of a particular type would be applied upon admission and marked "not applicable" to questions related to factors for or against bed rail use and what alternative options were trialled. The RN who completed the form in August 2018, selected that bed rails of a specific type would be applied and documented that a key factor for their use was based on resident request. All other questions related to alternative options trialled and sleep pattern and history were left blank.

Staff members #101, #102, #104 and #105 reported that they had not received any training or education with respect to completing bed safety assessments or what safety risks were associated with the bed systems in their home. According to the Associate Director of Care (ADOC), no formal education sessions had been developed for the staff.

The ADOC reported that a new policy related to bed rail risk assessments was developed in July 2018, but had not been fully implemented at the time of inspection. Sleep assessments were not conducted before September 2018, to determine whether residents with bed rails had any behaviours or sleep conditions that would increase their risk of bed system related injuries. The policy included procedures for the nursing staff to place residents upon admission in beds without bed rails until it could be established that they were appropriate and safe after a period of direct resident observation while sleeping in their beds. The personal support workers were included in the process and required to document their observations in a software program called "Point of Care".

The license therefore did not ensure that residents who used bed rails were assessed in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this   10th   day of December, 2018

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

Original report signed by the inspector.

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2018_539120_0043
Log No. / Registre no:	026043-18
Type of Inspection / Genre d'inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Nov 5, 2018
Licensee / Titulaire de permis :	The Regional Municipality of Niagara 1815 Sir Isaac Brock Way, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	Linhaven 403 Ontario Street, St. Catharines, ON, L2N-1L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Karen Pow

To The Regional Municipality of Niagara, 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 be compliant with O. Reg. 79/10, s.15(1)(a).

Specifically, the licensee must complete the following;

1. Revise or amend the current "Bed Rail Risk Assessment" form, under section 2, entitled "Assessment and Risk" to include additional questions related to the resident that can increase their likelihood of becoming injured while in bed with one or more bed rails applied as per 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".

2. Revise or amend the current Point of Care questionnaire related to sleeping tasks to include additional questions relevant to assessing the resident for certain risks associated with bed rail use while in bed. The questions should be related to the types of injury that are associated with bed systems 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).

3. Re-assess all residents who have been provided with one or more assist rails, using the amended "Bed Rail Risk Assessment" form and ensure the forms are fully completed and especially with respect to;

a. 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
b. the safety risks associated with the bed rail, if applied and deemed necessary where an alternative was not successful, while the resident is asleep for a specific period of time.

4. All registered staff who participate in the assessment of residents where bed rails are used shall receive face to face education so that they have an understanding of and are 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. All PSWs who will be involved in completing the sleeping tasks on Point of Care shall be given face to face education so that they have an understanding of and are able to complete the questions associated with a resident's bed system and associated hazards and risks.

6. Amend the current "Bed Rail Risk Assessment" policy RKM00-025 revised July 2018, to include additional and relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) and the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" related to the identification of risk factors associated with bed rail use. At a minimum the policy shall include;

a) guidance for the assessors in being able to make clear decisions based on

the data acquired by the various team members and to conclude and document the risk versus the benefits of the application of one or more bed rails for residents; and
b) alternatives available for the replacement of bed rails; and
c) interventions available for the resident that are used in conjunction with a bed rail if certain risks are identified; and
d) the role of the Substitute Decision Maker (SDM) and resident in selecting the appropriate device for bed mobility; and
e) links to references used to develop the policy.

7. Update the written plan of care for those residents where changes were identified after re-assessing each resident who used one or more bed rails. The plan of care shall include how many bed rails are to be applied, if only one bed rail is being applied, on what side and for what reason.

Grounds / Motifs :

1. The licensee failed to ensure that, where bed rails were used, that the resident was assessed in accordance with prevailing practices to minimize risk to the resident.

The Director of the Ministry of Health and Long Term Care sent a memorandum to all long term care home administrators on August 12, 2012, identifying a specific document from Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards (2008)". The Director expected the administrators to follow the recommendations in the document to reduce or mitigate the risk of bed-related hazards. Included in the Health Canada guidelines, are the titles of two additional documents (companion guides) which further provide specific guidance in assessing residents who use one or more bed rails and how to mitigate bed systems that do not pass entrapment zone specifications. The companion guide for assessing residents is entitled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003", and provides the necessary guidance in establishing a clinical assessment where bed rails are used by residents. The companion guide for mitigating bed systems is entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". The Health Canada Guidelines and the two companion guides are therefore the "prevailing practices" under s. 15(1) of O. Reg. 79/10 and shall be complied with.

In September 2018, resident #001 attempted to exit their bed unassisted. Interview with personal support worker (PSW) #101 revealed that they were alerted to the resident's room. When they arrived, the PSW realized that they required additional assistance and RN #104 and RPN #105 responded to assist the resident. The resident sustained a bed system related injury and was transferred to hospital for further assessment and returned on the same date. Both bed rails were removed the day after the incident. The PSW reported that the resident had previously sustained a fall and that the resident often demonstrated a behaviour and had a specific level of care for bed mobility.

The resident's bed was observed at the time of inspection and no bed rails were attached to the frame. According to bed system test records obtained from the housekeeping manager, the resident's bed was measured for entrapment zones in and around the rails 20 days prior to the incident and the bed system passed.

According to the resident's written plan of care, last revised in August 2018, the resident was diagnosed with several risk factors associated with an increase in risk related to bed system related injury. The plan included that their bed was equipped with bed rails of a specific type which did not restrict movement. The intervention was listed under the focus for bed mobility along with the added intervention that the resident required assistance with transfers, assistance for bed mobility and specific positioning when sleeping. Under the focus for risk of falls, specific interventions were included and confirmed to have been in place. The plan of care for bed mobility status was not consistent with the information acquired from staff and the clinical notes. Positioning at the time of the incident was not documented within the clinical notes.

According to the resident's bed safety assessment, the resident was admitted in May 2018, and the assessment was completed on the same date. According to RN #102, who completed the assessment and was new to the position, the resident was identified to have at least one risk factor that placed them at higher risk of bed safety related injury when bed rails were applied. The RN stated that they did not know the resident's sleep habits or patterns while in bed over a period of time to determine what risks were prevalent. The RN documented under question #2a and #2b against the use of bed rails as the resident was able to complete some tasks. Yet, under question #3, the RN selected that the resident would use bed rails of a specific type. According to RN #102, they did not know that the specified type of bed rails were considered bed rails and they

thought that bed system related injury only occurred with bed rails that were full length. In August 2018, the resident was re-assessed by a different RN (#106) who documented that bed rails of a specific type would be applied at the request of the resident. No documentation was made related to what bed rail alternatives were trialled before applying the bed rails and no documentation was made related to results from a sleep observation process to determine if any additional risks were present.

According to sleep related data collected by PSWs for resident #001 several weeks before and after the incident, the resident was in bed and sleeping for more than half of the the time. On other nights, the resident was documented to be either awake or out of bed. The majority of the observations were documented only once for the entire night, between 0400 and 0600 hours. No data was gathered to determine what type of risks needed to be observed while in bed. The questions included whether the resident slept through the night, was awake but in bed or was awake and out of bed. One day before the incident, a PSW documented that the resident was up and with staff twice during specific times. The same was documented on the date of the incident. The questions that the PSWs were required to answer were vague and not related directly to bed rail safety while in bed. According to the Clinical Guidelines, monitoring residents for specific behaviours while in bed, such as excessive bed movement, delirium, sleep related disorders, limbs through bed rails openings, playing with the bed rails, awareness of the bed rail and other activities would establish a better understanding of resident safety risks when bed rails are applied. These types of questions were discussed with the ADOC as more appropriate in deciding whether a bed rail would be appropriate and safe for the residents.

Two additional residents with the similar risk factors and whose beds were observed during the inspection to be equipped with two bed rails were reviewed during the inspection. Neither resident had a formal sleep assessment completed and did not have any bed rail alternatives trialled before having two bed rails applied to their beds. Although the residents were not in bed at the time of the inspection, both residents required bed rails according to their most recent plan of care and bed safety assessments.

According to resident #002's written plan of care, last revised in August 2018, the resident was diagnosed with several risk factors that placed them at higher risk of bed system related injury when bed rails were applied. The plan included that the resident's bed was equipped with specific type of bed rails which did not

restrict movement. The intervention was listed under the focus for bed mobility along with the requirement for supervision. Under the focus for risk of falls, specific interventions were included.

Resident #002 was assessed for bed safety by an RN in November 2017 and again in August 2018, and the assessments included documentation that they had at least one risk factor that placed them at higher risk of bed system related injury when bed rails were applied. Neither assessment included questions related to other risk factors such as medication use, pain, incontinence, sleep related disorders, behaviours, pain or falls risk. The assessment dated 2017, included that bed rails of a specific type would be used by the resident for bed mobility and a note that there were no concerns related to the use of the bed rails. Questions regarding what alternatives were trialled and what key factors for or against the use of the bed rails were not answered. The bed rail risk assessment completed in August 2018, which was a quarterly assessment, was revised and included questions related to sleep pattern and history. This particular question, along with key factors for or against bed rail use and alternatives considered or trialled were not answered. The questions that were not answered were essential in determining whether bed rails would be safe for the resident to use.

According to resident #003's written plan of care, last revised in August 2018, the resident was diagnosed with several risk factors that increased their risk of bed system related injury when bed rails were applied. The plan included that the resident's bed was equipped with bed rails of a particular type which did not restrict movement. The intervention was listed under the focus for bed mobility along with the added intervention that the resident required supervision. Under the focus for risk of falls, specific interventions were included.

Resident #003 was assessed for bed safety by an RN on admission in February 2018 and again in August 2018, as part of a quarterly assessment. Both assessments included documentation that the resident had at least three risk factors that placed them at higher risk of bed system related injury when bed rails were applied. No questions were listed related to risk factors such as medication use, pain, incontinence, sleep related disorders, behaviours or falls risk. The RN selected that bed rails of a particular type would be applied upon admission and marked "not applicable" to questions related to factors for or against bed rail use and what alternative options were trialled. The RN who completed the form in August 2018, selected that bed rails of a specific type

would be applied and documented that a key factor for their use was based on resident request. All other questions related to alternative options trialled and sleep pattern and history were left blank.

Staff members #101, #102, #104 and #105 reported that they had not received any training or education with respect to completing bed safety assessments or what safety risks were associated with the bed systems in their home. According to the Associate Director of Care (ADOC), no formal education sessions had been developed for the staff.

The ADOC reported that a new policy related to bed rail risk assessments was developed in July 2018, but had not been fully implemented at the time of inspection. Sleep assessments were not conducted before September 2018, to determine whether residents with bed rails had any behaviours or sleep conditions that would increase their risk of bed system related injuries. The policy included procedures for the nursing staff to place residents upon admission in beds without bed rails until it could be established that they were appropriate and safe after a period of direct resident observation while sleeping in their beds. The personal support workers were included in the process and required to document their observations in a software program called "Point of Care".

The license therefore did not ensure that residents who used bed rails were assessed in accordance with prevailing practices to minimize risk to the resident

This order is based upon three factors where there has been a finding of non-compliance in keeping with s.299(1) of Ontario Regulation 79/10. The factors include severity, scope and history of non-compliance. In relation to this incident, the severity was determined to be a level 3, as one resident was actually harmed. The scope was determined to be a level 3, as three out of three residents reviewed were not assessed in accordance with prevailing practices. The history related to non-compliance with s.15(1) was determined to be a level 2, as non-compliance was issued in other non-related areas over the last 3 years.
(120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 29, 2019

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

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 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

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 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

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 5th day of November, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

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