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 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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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Aug 10, 2016	2016_189120_0042	001885, 001886, 001887-16	Follow up

Licensee/Titulaire de permis

NIAGARA HEALTH SYSTEM
63 THIRD STREET WELLAND HOSPITAL SITE WELLAND ON L3B 4W6

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

NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT
155 Ontario Street St. Catharines ON L2R 5K3

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 Follow up inspection.

This inspection was conducted on the following date(s): June 29 & 30, 2016

An inspection (RQI 2015-247508-0010) was previously conducted between May 25 and June 11, 2015 at which time Orders #002 and #003 were issued related to bed safety. For this follow up inspection, the Orders were not complied with and remain outstanding. The same non-compliance was issued for inspections conducted April 8-24, 2014 and January 20- 21, 2015.

An Order related to the home's maintenance program was issued during an inspection conducted in February 2015. Upon follow-up in June 2015, the Order was not fully complied with and was re-issued. For this follow up inspection, the conditions in the Order were not met and the Order remains outstanding. See below for details.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care, Registered Nurses and residents.

During the course of the inspection, the inspector toured the home, observed resident bed systems and residents in bed, reviewed the home's maintenance audit check list and maintenance policy, bed safety policy, bed system evaluation (entrapment zones) results, clinical resident assessments for bed rail safety, staff training and education materials for bed safety and the written plan of care for randomly selected residents.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Maintenance
Safe and Secure Home

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee did not ensure that where bed rails were used, (1) that the resident was assessed and (2) that his or her bed system was evaluated in accordance with prevailing practices to minimize risk to the resident.

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

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

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who

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

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be developed in accordance with the Clinical Guidance document identified above. According to the Director of Care, the Clinical Guidance document was not reviewed by herself or her registered staff after the last Order was issued on July 20, 2015 and was therefore not incorporated into their existing questionnaire or tool titled "Bedrail Utilization Assessment/Reassessment(3)" which was used to assess residents for bed rail use/safety.

Bed rail safety assessments were reviewed for 8 residents (#001 to #008) who were observed to be either in bed and had one or more bed rails in use or had bed rails elevated on their beds and a care plan requiring them to have at least one bed rail in use while in bed.

A) The assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours were evaluated or observed while sleeping in bed with or without the application of bed rails. The licensee's policy titled "Bed Safety - Prevention

of Entrapment" dated May 2015 directed registered staff to "conduct or designate the completion of a Bed Safety Analysis when the bed frame is changed or prior to the resident being transferred onto the surface/bed frame". This particular analysis was not related to a clinical assessment of the resident, but an assessment of the bed for entrapment zones. The licensee's policy or Bedrail Utilization Assessment form did not include any information regarding how long residents were to be observed, by whom and the specific behaviours that were to be monitored during a specified observation period.

B) The Bedrail Utilization Assessment form did not include a section that could be completed by the assessor indicating what bed rail alternatives were trialled prior to applying the bed rails if they were indicated for a medical symptom or condition. Examples on the form included but were not limited to bed exit alarm, call bell within reach, decreased time in bed, increased monitoring, call bell availability and hi/low bed. These options are considered interventions for other bed related safety issues and are not bed rail alternatives such as a transfer pole, raised perimeter mattress (easier to grab than a flat mattress when being repositioned), adjustable bolsters or teaching the resident new transfer or re-positioning techniques. For 7 out of the 8 identified residents, the assessor concluded that the residents were to have both bed rails applied for safety, bed mobility or both. The term "safety" was not defined and registered staff interviewed could not express what "unsafe" condition was being prevented other than the resident falling out of bed. According to falls prevention best practices and bed manufacturers, bed rails are not indicated for use to prevent falls from bed. The Bedrail Utilization Assessment form did not clearly identify what alternatives were trialled to minimize or eliminate the risks of strangulation, suspension, entrapment, entanglement, injuries, skin tears or bruising if bed rails were to be applied and whether the alternative was effective or not.

C) The questions included in the Bedrail Utilization Assessment form did not include several key questions related to sleep patterns, behaviours and medication use. Relevant questions were noted to include resident overall mobility, falls history, cognition, bed rail use concerns such as a history of trying to climb out of bed when side rails were in place and if the resident had experienced any bed rail injuries or had become entangled in the past. When these questions were answered with either a "yes" or a "no", the form did not provide any direction to registered staff. The form included a question related to whether the resident was able to "state their preference about bed rails" and if the answer was "yes", the resident or SDM was required to answer whether they had been informed of the bed rail risks and were directed to sign a "statement of understanding". There was no formal conclusion other than a section titled "Side Rail

Recommendation" requiring the assessor to pick one of 7 options about why a bed rail was to be applied (bed mobility, safety, SDM request) and how many and on what side of the bed. One option was available for selection where by both bed rails would be applied based on the "insistence of the resident or SDM". No option was available indicating that bed rails were "not recommended" and the reasons for the resident based on the outcomes of an observation period conducted by an interdisciplinary team of staff members.

A registered staff member reported that they felt pressured by the SDMs who insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.

D) The assessment form did not specify what interdisciplinary staff members participated in the evaluation of the resident. The assessment forms reviewed did not have any names listed on the form. According to two registered staff members, the forms were completed by the registered staff members with input from other non-registered staff members but their names and positions were not included.

E) The written plan of care was reviewed for 8 residents after observing one bed rail raised on their beds, 3 of which were in bed at the time of the inspection.

Resident #001 was observed on June 30, 2016 to be lying on a soft therapeutic air mattress with both full rails elevated and no bed accessories such as bolsters, gap fillers or rail pads observed in place. According to a check list used by the home titled "Audit of Bed/Surface Numbers, Bumper Pads and Bolster Use", the resident was listed as "special" for the type of mattress provided and the check list stipulated that no bolsters or bumper pads were required. No information about the bed could be located, whether tested or not in the records provided for 2014 or 2015 with the bed's serial #13811. However, based on other similar therapeutic surfaces listed in the records for 2014 and 2015, the beds were identified by the contractor to have passed zones 2-4 (all areas around the bed rail), despite the fact that soft air mattresses cannot be tested or can pass zones 2-4 (without a hard perimeter edge). According to the resident's most recent written plan of care, both full bed rails were to be elevated for assistance with turning in bed, bed mobility and for "safety". According to the resident's Bedrail Utilization Assessment dated May 2016, no safety issues were identified despite the fact that

therapeutic mattresses are high risk for entrapment due to their soft design and flexibility. The assessment included that the resident had a history of falls from bed, that bed rails were tried for bed mobility/transfers and as a conclusion, both side rails were to be used for bed mobility. No alternatives were trialled prior to the application of bed rails, no accessories were provided to mitigate entrapment risks and no safety risks were identified with the use of the therapeutic mattress for this resident.

Resident #002 was observed on June 30, 2016 in bed on a therapeutic soft air mattress with both full length bed rails elevated. The bed rails had rounded ends which increases zone 4 entrapment risk along with the additional risk of entrapment due to the soft compressible nature of the mattress. According to the October 2015 bed entrapment audit results, the bed passed entrapment zones 2-4. No bolsters or rail pads were included. The status of the safety of the bed rails was suspect and the concern raised with with the Director of Care and the Administrator. According to a check list used by the home titled "Audit of Bed/Surface Numbers, Bumper Pads and Bolster Use", the resident was listed as "special" for the type of mattress provided and the check list stipulated that no bolsters or bumper pads were required. The resident's Bedrail Utilization Assessment dated May 2016 indicated that both side rails were to be "up for safety". The resident's clinical records identified the resident to be confused and not able to make decisions about their bed rail. The resident's written plan of care identified that the resident "required the assistance of 2 staff to reposition them in bed" and that "2 full bed rails were to be up at all times when in bed (restraint)". No reason was given for the use of the bed rails as a restraint. No alternatives were documented to have been trialled before the application of the bed rails. No interventions were applied to mitigate the zones of entrapment that are inherent on a soft therapeutic mattress.

Resident #003 was observed on June 30, 2016 in bed on a firm foam mattress with both 1/4 bed rails in the elevated position. The bed was tested for entrapment in October 2015 and passed zones 1-4. The bed rails, based on their model and design were known to the inspector as having failed zones 2-4 in other LTC homes. When the bed was observed in detail, the rail ends were rounded and the zone 4 gap was large enough for a leg or neck to become wedged between the bed rail end and the mattress. The status of the safety of the bed rails was suspect and the concern raised with both the Director of Care and the Administrator. The resident's most recent written plan of care identified that the resident was to have the "upper 1/2 bed rail x2 when in bed for safety and to ensure that the PASD is in place". The resident's Bedrail Utilization Assessment dated June 2013 included that the resident's SDM requested the bed rails, that the bed rails were tried for bed mobility/transfers and that the resident could turn side to side but was

primarily immobile. No option under "Side Rail Recommendation" was selected. No interventions were applied to mitigate the observed zones of entrapment 2-3 and no alternatives were documented to have been trialled before the application of the bed rails. The resident was admitted to the home on the same date as the date of the bed rail assessment and therefore no observation period was included in the assessment to determine the resident's sleeping patterns, habits and behaviours while in bed.

(2) The licensee did not ensure that where bed rails were used, that the residents' bed systems were evaluated in accordance with prevailing practices to minimize risk to the resident. Prevailing practices have been identified by the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch as a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008.

The licensee commissioned a company to complete a bed system evaluation for entrapment zones 1 through 4 of all resident bed systems on September 4, 2014 and again in October 2015. During an inspection in January 2015, the testing method completed during the first audit was suspected of being incorrect as the auditor tested and passed zones 2-4 for approximately 12 therapeutic air mattresses. The concerns were raised at that time with management staff and identified in the inspection report. The therapeutic mattresses were observed to be very soft and quite flexible with no reinforced sides for rigidity at the time of inspection. The company evaluator concluded that "there was no way to accurately test these gaps as they will change with each cycle, however we test them to simply ensure the mattress, rail and bed frame work together". The auditor revealed in this statement that there were gaps and that there was "no way to accurately test these gaps" but documented that the beds "passed". According to the prevailing HC Guidelines, therapeutic air mattresses are excluded from the dimensional limit recommendations and therefore cannot be measured like other hospital beds with firm conventional mattresses. The "highly compressible nature of the mattresses poses technical difficulties in measuring certain dimensional gaps in these type of products." Any auditor conducting an evaluation of such a bed can only comment on the dimensional limit recommendations in zone 1 (within the bed rail), unless the therapeutic mattress has reinforced side walls.

During this follow-up inspection, the same beds with a therapeutic air mattress (identified by an inventory or serial number) which were previously identified as passing entrapment zones 2-4 in 2014 were noted to to have passed all entrapment zones during another

evaluation by the same company conducted in October 2015. Documentation provided by the Administrator revealed that all beds passed entrapment zones 1-4. During this inspection, several beds with conventional mattresses were observed to have rounded bed rail ends or bed rails that were slightly elevated so that the bottom rung was above the height of the mattress. Based on the HC Guidelines and experience with various different models and styles of bed systems, the types of bed rails observed to be in use on various resident beds were suspected of having failed entrapment zones 2-4. It was difficult to determine if the beds were measured accurately or fully in accordance with the HC Guidelines. The licensee did not have their own cone and cylinder measurement tool to be able to validate whether the beds could pass entrapment zones 2-4 at the time of inspection.

The concern was raised with the Administrator in May 2015 and again during this inspection that the company that was chosen to conduct the evaluation of the bed systems may not have followed the HC Guidelines and therefore did not provide accurate information about the entrapment risk of the beds.

Some time after October 2015 (no specific date could be provided), approximately 20 adult hospital beds were acquired from a hospital and placed into use for LTC residents. The beds were all equipped with split rails (4 quarter sized bed rails in total). The bed rails were not evaluated to determine if they passed all four zones of entrapment per rail. The entrapment and safety status of the beds was therefore unknown at the time of inspection. Many residents provided with one of these beds had one or more bed rails elevated or in use during the tour of the home (16, 19, 21, 22, 26, 30, 32, 34, 35, 113, 116). [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

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

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Findings/Faits saillants :

The licensee did not ensure that procedures were in place for routine, preventive and remedial maintenance.

During previous inspections, conducted April 2014 and January 2015, inspectors identified tubs, flooring material, fixtures, furnishings, interior surfaces and beds to be in poor condition. Written procedures related to preventive and remedial maintenance for the fixtures, furnishings and surfaces were not available for review as they had not been developed. Non compliance (Orders) was issued following both inspections. During a follow-up inspection on June 4, 2015, the Administrator provided a completed audit of the status or condition of the various interior surfaces and furnishings and a plan to address their findings. However no procedures had been developed. During this follow-up visit, the Administrator provided a copy of a maintenance policy and a preventive maintenance audit check list for resident bedroom/washroom surfaces and furnishings. No written procedures were included and the preventive maintenance audit and did not include common area inspections such as tub/shower rooms, common washrooms, lounges, dining rooms and corridors. [s. 90. (1) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

Issued on this 11th day of August, 2016

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

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

Ministére de la Santé et des Soins de longue durée

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

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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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	BERNADETTE SUSNIK (120)
Inspection No. / No de l'inspection :	2016_189120_0042
Log No. / Registre no:	001885, 001886, 001887-16
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Aug 10, 2016
Licensee / Titulaire de permis :	NIAGARA HEALTH SYSTEM 63 THIRD STREET, WELLAND HOSPITAL SITE, WELLAND, ON, L3B-4W6
LTC Home / Foyer de SLD :	NIAGARA HEALTH SYSTEM, WELLAND HOSPITAL SITE, EXTENDED CARE UNIT 155 Ontario Street, St. Catharines, ON, L2R-5K3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Colleen Winger

To NIAGARA HEALTH SYSTEM, 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

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2015_247508_0010, CO #002;

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The licensee shall complete the following:

1. Select an alternative company, from the company that was selected in 2014 and 2015, to re-evaluate (measure) all of the beds in the home for zones of entrapment 1-4. The chosen evaluator shall be fully knowledgeable of the prevailing practice guidelines that apply to adult hospital beds produced by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, March 2008".

2. Conduct a re-evaluation of all bed systems using the alternative company described in paragraph 1 to this Order.

3. The bed system identification that will be used to document which bed was evaluated for entrapment zones shall be consistent, using either a bed inventory number or the bed serial number.

3. Soft therapeutic mattresses shall not be measured or evaluated for zones 2-4 unless they have a firm perimeter or reinforced side walls or are described by the manufacturer as exhibiting the same characteristics as a foam mattress. Soft therapeutic mattresses shall be treated as a "failed" bed and appropriate risk interventions applied to ensure that the risk of entrapment is mitigated where a resident has been provided such a mattress and is using one or more bed rails.

4. Any bed that has failed one or more zones of entrapment and where a resident has been assessed to require one or more bed rails, shall be modified in accordance with a companion guide identified in the Health Canada Guidelines (as identified in paragraph 1 of this Order) titled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006).

5. The results of the bed system re-evaluation shall be made available to the interdisciplinary team who participate in evaluating each resident for use and safety of bed rails.

6. A record shall be made and kept, including the date, the bed identifier number, what specific change was made to the bed, who made the changes and the entrapment results of the bed system re-evaluation.

Grounds / Motifs :

1. The licensee did not ensure that where bed rails were used, that the residents' bed systems were evaluated in accordance with prevailing practices to minimize risk to the resident. Prevailing practices have been identified by the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch as a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008.

The licensee commissioned a company to complete a bed system evaluation for entrapment zones 1 through 4 of all resident bed systems on September 4, 2014 and again in October 2015. During an inspection in January 2015, the testing method completed during the first audit was suspected of being incorrect as the auditor tested and passed zones 2-4 for approximately 12 therapeutic air mattresses. The concerns were raised at that time with management staff and identified in the inspection report. The therapeutic mattresses were observed to be very soft and quite flexible with no reinforced sides for rigidity at the time of inspection. The company evaluator concluded that "there was no way to accurately test these gaps as they will change with each cycle, however we test them to simply ensure the mattress, rail and bed frame work together". The auditor revealed in this statement that there were gaps and that there was "no way to accurately test these gaps" but documented that the beds "passed". According to the prevailing HC Guidelines, therapeutic air mattresses are excluded from the dimensional limit recommendations and therefore cannot be measured like other hospital beds with firm conventional mattresses. The "highly compressible nature of the mattresses poses technical difficulties in measuring certain dimensional gaps in these type of products." Any auditor conducting an evaluation of such a bed can only comment on the dimensional limit recommendations in zone 1 (within the bed rail), unless the therapeutic mattress has reinforced side walls.

During this follow-up inspection, the same beds with a therapeutic air mattress (identified by an inventory or serial number) which were previously identified as passing entrapment zones 2-4 in 2014 were noted to to have passed all entrapment zones during another evaluation by the same company conducted in October 2015. Documentation provided by the Administrator revealed that all beds passed entrapment zones 1-4. During this inspection, several beds with conventional mattresses were observed to have rounded bed rail ends or bed

rails that were slightly elevated so that the bottom rung was above the height of the mattress. Based on the HC Guidelines and experience with various different models and styles of bed systems, the types of bed rails observed to be in use on various resident beds were suspected of having failed entrapment zones 2-4. It was difficult to determine if the beds were measured accurately or fully in accordance with the HC Guidelines. The licensee did not have their own cone and cylinder measurement tool to be able to validate whether the beds could pass entrapment zones 2-4 at the time of inspection.

The concern was raised with the Administrator in May 2015 and again during this inspection that the company that was chosen to conduct the evaluation of the bed systems may not have followed the HC Guidelines and therefore did not provide accurate information about the entrapment risk of the beds.

Some time after October 2015 (no specific date could be provided), approximately 20 adult hospital beds were acquired from a hospital and placed into use for LTC residents. The beds were all equipped with split rails (4 quarter sized bed rails in total). The bed rails were not evaluated to determine if they passed all four zones of entrapment per rail. The entrapment and safety status of the beds was therefore unknown at the time of inspection. Many residents provided with one of these beds had one or more bed rails elevated or in use during the tour of the home (16, 19, 21, 22, 26, 30, 32, 34, 35, 113, 116).

This Order is based upon the above findings of non-compliance and three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 2 (potential for resident harm), the scope is 2 (pattern - more than one bed system) and the compliance history is 4 (ongoing non-compliance with a Compliance Order). Non-compliance was previously issued for inspections conducted April 8-24, 2014, January 20- 21, 2015 and May 25-June11, 2015. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2015_247508_0010, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall complete the following:

1. Amend the home's existing "Bedrail Utilization Assessment/Reassessment" form to include all relevant questions and guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003) 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". The amended questionnaire shall, at a minimum, include questions that can be answered by the assessors related to:

a. the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, behaviours and other relevant factors prior to the application of any bed rails; and

b. the alternatives that were trialled prior to using one or more bed rails and document whether the alternative was effective or not during a specified observation period.

2. The names of the interdisciplinary team members who participate in assessing the residents shall be included on the amended bed safety assessment form.

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

4. The existing on-going monitoring process to ensure that all staff apply the bed rails and/or mitigating entrapment zone accessories as specified in the plan of care (i.e. when, what accessory, on what side and how many bed rails) shall continue.

5. Develop an education and information package that can be made available to staff, families and residents identifying the regulations and prevailing practices governing adult hospital beds in Ontario, the risks of bed rail use, whether beds pass or fail entrapment zone testing, the role of the SDM and licensee with respect to resident assessments and any other relevant facts or myths associated with bed systems and the use of bed rails.

6. All staff in the home who provide resident care and are involved in assisting a resident to bed shall be provided with detailed information, whether in a group setting or one on one regarding the risks of bed rail use which includes but is not limited to; the location of entrapment zones 1-4, how to identify safety risks when a resident is in bed, when to report their concerns and to whom, whether beds passed or failed any entrapment zone when tested, where to find individual resident bed rail use directives, and any other relevant facts or myths associated with bed systems and the use of bed rails.

7. Develop a policy that clearly identifies the roles and responsibilities of the various interdisciplinary team members who participate in evaluating each resident for bed safety risks and bed rail use. The policy shall include written procedures that clearly identify how residents will be evaluated for bed safety 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).

Grounds / Motifs :

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

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

Prevailing practices includes using predominant, generally accepted widespread practice as the basis for clinical decisions. The companion documents are also prevailing practices and provide necessary guidance in establishing a clinical assessment where bed rails are used.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003". Within this document, recommendations are made that all residents who use one or more bed rails be evaluated by an interdisciplinary team over a period of time while in bed to determine sleeping patterns, habits and potential safety risks posed by using one or more bed rails. To guide the assessor, a series of questions would be answered to determine whether the bed rail(s) are a safe device for residents while in bed (when fully awake and while they are asleep). The Clinical Guidance document also emphasizes the need to document clearly whether alternative interventions were trialled if bed rails are being considered to treat a medical symptom or condition and if the interventions were appropriate or effective and if they were previously attempted and determined not to be the treatment of choice for the resident. Where bed rails are considered for transferring and bed mobility, discussions need to be held with the resident/substitute decision maker (SDM) regarding options for reducing the risks and implemented where necessary. Other questions to be considered would include the resident's medical status, cognition, behaviours, medication use and any involuntary movements, toileting

habits, sleeping patterns/habits and environmental factors, all of which could more accurately guide the assessor in making a decision, with input (not direction) from the resident or their SDM about the necessity and safety of a bed rail (medical device). The final conclusion would be documented as to whether bed rails would be indicated or not, why one or more bed rails were required, the type of bed rail required, when the bed rails were to be applied, how many, on what sides of the bed and whether any accessory or amendment to the bed system was necessary to minimize any potential injury or entrapment risks to the resident.

The licensee's bed rail use clinical assessment form and process was reviewed and it was determined not to be developed in accordance with the Clinical Guidance document identified above. According to the Director of Care, the Clinical Guidance document was not reviewed by herself or her registered staff after the last Order was issued on July 20, 2015 and was therefore not incorporated into their existing questionnaire or tool titled "Bedrail Utilization Assessment/Reassessment(3)" which was used to assess residents for bed rail use/safety.

Bed rail safety assessments were reviewed for 8 residents (#001 to #008) who were observed to be either in bed and had one or more bed rails in use or had bed rails elevated on their beds and a care plan requiring them to have at least one bed rail in use while in bed.

A) The assessment process did not incorporate a process by which the resident's sleep patterns, habits and behaviours were evaluated or observed while sleeping in bed with or without the application of bed rails. The licensee's policy titled "Bed Safety - Prevention of Entrapment" dated May 2015 directed registered staff to "conduct or designate the completion of a Bed Safety Analysis when the bed frame is changed or prior to the resident being transferred onto the surface/bed frame". This particular analysis was not related to a clinical assessment of the resident, but an assessment of the bed for entrapment zones. The licensee's policy or Bedrail Utilization Assessment form did not include any information regarding how long residents were to be observed, by whom and the specific behaviours that were to be monitored during a specified observation period.

B) The Bedrail Utilization Assessment form did not include a section that could be completed by the assessor indicating what bed rail alternatives were trialled

prior to applying the bed rails if they were indicated for a medical symptom or condition. Examples on the form included but were not limited to bed exit alarm, call bell within reach, decreased time in bed, increased monitoring, call bell availability and hi/low bed. These options are considered interventions for other bed related safety issues and are not bed rail alternatives such as a transfer pole, raised perimeter mattress (easier to grab than a flat mattress when being repositioned), adjustable bolsters or teaching the resident new transfer or re-positioning techniques. For 7 out of the 8 identified residents, the assessor concluded that the residents were to have both bed rails applied for safety, bed mobility or both. The term "safety" was not defined and registered staff interviewed could not express what "unsafe" condition was being prevented other than the resident falling out of bed. According to falls prevention best practices and bed manufacturers, bed rails are not indicated for use to prevent falls from bed. The Bedrail Utilization Assessment form did not clearly identify what alternatives were trialled to minimize or eliminate the risks of strangulation, suspension, entrapment, entanglement, injuries, skin tears or bruising if bed rails were to be applied and whether the alternative was effective or not.

C) The questions included in the Bedrail Utilization Assessment form did not include several key questions related to sleep patterns, behaviours and medication use. Relevant questions were noted to include resident overall mobility, falls history, cognition, bed rail use concerns such as a history of trying to climb out of bed when side rails were in place and if the resident had experienced any bed rail injuries or had become entangled in the past. When these questions were answered with either a "yes" or a "no", the form did not provide any direction to registered staff. The form included a question related to whether the resident was able to "state their preference about bed rails" and if the answer was "yes", the resident or SDM was required to answer whether they had been informed of the bed rail risks and were directed to sign a "statement of understanding". There was no formal conclusion other than a section titled "Side Rail Recommendation" requiring the assessor to pick one of 7 options about why a bed rail was to be applied (bed mobility, safety, SDM request) and how many and on what side of the bed. One option was available for selection where by both bed rails would be applied based on the "insistence of the resident or SDM". No option was available indicating that bed rails were "not recommended" and the reasons for the resident based on the outcomes of an observation period conducted by an interdisciplinary team of staff members.

A registered staff member reported that they felt pressured by the SDMs who

insisted that a bed rail be applied regardless of the risks associated with bed rails explained to them. As such, the licensee followed the direction given by SDMs into their practices without balancing the resident's or SDM's input with the licensee's obligation to conduct an individualized resident assessment and evaluation in accordance with prevailing practices as required by the Regulation.

D) The assessment form did not specify what interdisciplinary staff members participated in the evaluation of the resident. The assessment forms reviewed did not have any names listed on the form. According to two registered staff members, the forms were completed by the registered staff members with input from other non-registered staff members but their names and positions were not included.

E) The written plan of care was reviewed for 8 residents after observing one bed rail raised on their beds, 3 of which were in bed at the time of the inspection.

Resident #001 was observed on June 30, 2016 to be lying on a soft therapeutic air mattress with both full rails elevated and no bed accessories such as bolsters, gap fillers or rail pads observed in place. According to a check list used by the home titled "Audit of Bed/Surface Numbers, Bumper Pads and Bolster Use", the resident was listed as "special" for the type of mattress provided and the check list stipulated that no bolsters or bumper pads were required. No information about the bed could be located, whether tested or not in the records provided for 2014 or 2015 with the bed's serial #13811. However, based on other similar therapeutic surfaces listed in the records for 2014 and 2015, the beds were identified by the contractor to have passed zones 2-4 (all areas around the bed rail), despite the fact that soft air mattresses cannot be tested or can pass zones 2-4 (without a hard perimeter edge). According to the resident's most recent written plan of care, both full bed rails were to be elevated for assistance with turning in bed, bed mobility and for "safety". According to the resident's Bedrail Utilization Assessment dated May 2016, no safety issues were identified despite the fact that therapeutic mattresses are high risk for entrapment due to their soft design and flexibility. The assessment included that the resident had a history of falls from bed, that bed rails were tried for bed mobility/transfers and as a conclusion, both side rails were to be used for bed mobility. No alternatives were trialled prior to the application of bed rails, no accessories were provided to mitigate entrapment risks and no safety risks were identified with the use of the therapeutic mattress for this resident.

Resident #002 was observed on June 30, 2016 in bed on a therapeutic soft air mattress with both full length bed rails elevated. The bed rails had rounded ends which increases zone 4 entrapment risk along with the additional risk of entrapment due to the soft compressible nature of the mattress. According to the October 2015 bed entrapment audit results, the bed passed entrapment zones 2 -4. No bolsters or rail pads were included. The status of the safety of the bed rails was suspect and the concern raised with with the Director of Care and the Administrator. According to a check list used by the home titled "Audit of Bed/Surface Numbers, Bumper Pads and Bolster Use", the resident was listed as "special" for the type of mattress provided and the check list stipulated that no bolsters or bumper pads were required. The resident's Bedrail Utilization Assessment dated May 2016 indicated that both side rails were to be "up for safety". The resident's clinical records identified the resident to be confused and not able to make decisions about their bed rail. The resident's written plan of care identified that the resident "required the assistance of 2 staff to reposition them in bed" and that "2 full bed rails were to be up at all times when in bed (restraint)". No reason was given for the use of the bed rails as a restraint. No alternatives were documented to have been trialled before the application of the bed rails. No interventions were applied to mitigate the zones of entrapment that are inherent on a soft therapeutic mattress.

Resident #003 was observed on June 30, 2016 in bed on a firm foam mattress with both 1/4 bed rails in the elevated position. The bed was tested for entrapment in October 2015 and passed zones 1-4. The bed rails, based on their model and design were known to the inspector as having failed zones 2-4 in other LTC homes. When the bed was observed in detail, the rail ends were rounded and the zone 4 gap was large enough for a leg or neck to become wedged between the bed rail end and the mattress. The status of the safety of the bed rails was suspect and the concern raised with both the Director of Care and the Administrator. The resident's most recent written plan of care identified that the resident was to have the "upper 1/2 bed rail x2 when in bed for safety and to ensure that the PASD is in place". The resident's Bedrail Utilization Assessment dated June 2013 included that the resident's SDM requested the bed rails, that the bed rails were tried for bed mobility/transfers and that the resident could turn side to side but was primarily immobile. No option under "Side Rail Recommendation" was selected. No interventions were applied to mitigate the observed zones of entrapment 2-3 and no alternatives were documented to have been trialled before the application of the bed rails. The resident was admitted to the home on the same date as the date of the bed rail

assessment and therefore no observation period was included in the assessment to determine the resident's sleeping patterns, habits and behaviours while in bed.

This Order is based upon the above non-compliance and three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 2 (potential for resident harm), the scope is 2 (pattern - more than one resident is affected) and the compliance history is 4 (ongoing non-compliance with a Compliance Order). Non-compliance was previously issued for inspections conducted April 8-24, 2014, January 20- 21, 2015 and May 25-June11, 2015. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 28, 2016

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2015_247508_0010, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee shall develop and implement written procedures that addresses a routine, remedial and preventive components for all interior surfaces, furnishings, fixtures and equipment within the home. The procedures shall include but not be limited to the following:

a) a description of the various roles and responsibilities of staff members who would be expected to either report maintenance concerns, audit the home or repair identified maintenance concerns; and

b) detailed guidelines for the auditor who is required to conduct the preventive inspection using the maintenance audit tool developed by the licensee that includes how to complete the form, when to submit it and to whom and how to prioritize the findings (high risk vs low risk). The procedure shall include who will respond to complete the identified findings and whether more than one person would need to be involved in addressing the concerns/findings (leak vs repair vs replacement), how long one could expect the task to take and documentation of the follow up actions taken; and

c) detailed information regarding the expectations for the condition of interior surfaces, equipment, furnishings and fixtures which includes where necessary, the manufacturer's guidelines (i.e. beds, tubs, lift equipment). The procedures shall differentiate the difference between a full inspection vs a quick check, when and who would conduct the quick vs full inspection; and

d) alternative measures identified if a repair or replacement is expected to be prolonged and would affect resident care and services in any way.

Grounds / Motifs :

1. The licensee did not ensure that procedures were in place for routine, preventive and remedial maintenance.

During previous inspections, conducted April 2014 and January 2015, inspectors identified tubs, flooring material, fixtures, furnishings, interior surfaces and beds to be in poor condition. Written procedures related to preventive and remedial maintenance for the fixtures, furnishings and surfaces were not available for review as they had not been developed. Non compliance (Orders) was issued following both inspections. During a follow-up inspection on June 4, 2015, the Administrator provided a completed audit of the status or condition of the various interior surfaces and furnishings and a plan to address their findings. However no procedures had been developed. During this follow-up visit, the Administrator provided a copy of a maintenance policy and a preventive maintenance audit check list for resident bedroom/washroom surfaces and furnishings. No written procedures were included and the preventive maintenance audit did not include common area inspections such as tub/shower rooms, common washrooms, lounges, dining rooms and corridors.

This Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. The severity is 2 (potential for harm), the scope is 2 (pattern) and the compliance history is 4 (ongoing non-compliance with a Compliance Order). (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2016

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 Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 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 10th day of August, 2016

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