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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 13, 2018	2018_689586_0017	014915-18	Resident Quality Inspection

Licensee/Titulaire de permis

Liuna Local 837 Nursing Home (Ancaster) Corporation
44 Hughson Street South HAMILTON ON L8N 2A7

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

Regina Gardens
536 Upper Paradise Road HAMILTON ON L9C 5E3

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

JESSICA PALADINO (586), AILEEN GRABA (682), BERNADETTE SUSNIK (120), KELLY CHUCKRY (611)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 26, 27, 28, 29, July 3, 4, 5 and 6, 2018.

The following Complaint Intake was inspected concurrently with the RQI:
023582-17 - Dining & Snack Service.

The following Critical Incident System (CIS) intakes were inspected concurrently with the RQI:
013507-16 - Prevention of Abuse & Neglect;
000116-17 - Prevention of Abuse & Neglect;
000126-17 - Prevention of Abuse & Neglect;
000350-17 - Prevention of Abuse & Neglect;
001905-17 - Medication Administration;
008611-17 - Prevention of Abuse & Neglect;
011615-17 - Prevention of Abuse & Neglect;
021196-17 - Prevention of Abuse & Neglect;
027054-17 - Prevention of Abuse & Neglect;
002949-18 - Prevention of Abuse & Neglect;
006427-18 - Fall Prevention & Management; and,
015536-18 - Fall Prevention & Management.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Environmental Services Supervisor (ESS), Registered Dietitian (RD), Social Worker (SW), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, dietary staff, residents and families.

During the course of the inspection, the inspector(s) toured the home, observed dining service, observed resident-staff interactions and care, observed resident bed systems and tested bed rails for function, tested the resident-staff communication and response system, observed lift and transfer equipment and supplies, reviewed maintenance logs, bed system entrapment test results, health records, policies and procedures, training records, staff files, and resident council meeting minutes.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Safe and Secure Home

During the course of this inspection, Non-Compliances were issued.

- **7 WN(s)**
- **2 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that all residents were protected from abuse by anyone. O. Reg. 79/10, s. 2 (1) defines physical abuse as the use of physical force by anyone

other than a resident that causes physical injury or pain.

On an identified date in 2017, the home submitted a CIS report #2922-000015-17, in which staff #121 witnessed resident #019 approach staff #120 and accuse them of causing an injury during care. Staff #121 reported this to staff #117, who then assessed the resident.

In an interview with staff #117 on an identified date in 2018, the staff member indicated that when they spoke with the resident after the incident, the resident told them that staff #120 had injured them.

A skin assessment completed after the incident and identified an area of altered skin integrity.

A review of the home's internal investigation notes, as well as interview with staff #117, confirmed that the area of altered skin integrity was not present prior to the incident.

In an interview with the DOC, they confirmed that the home's internal investigation determined that staff #120 caused the injury during care. The resident was upset by the incident. The staff member was terminated. The DOC confirmed that the findings of the investigation concluded that resident #019 was not protected from physical abuse by staff #120.

This area of non-compliance was identified during a CIS inspection, log #011615-17 conducted concurrently during this RQI. (586).

B) The licensee failed to ensure that all residents were protected from abuse by anyone.

O.Reg. 79/10, s. 2 (1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident,

On an identified date in 2017, the home submitted a CIS report #2922-000026-17, which indicated that staff #122 allegedly physically abused and was rough with resident #027. No injuries to resident #027 were noted.

A review of resident #027's clinical record was completed. Investigative notes indicated

that on staff #123 reported to the home's management that staff #124 and #125 witnessed an incident of alleged abuse of staff #122 toward resident #027. This was confirmed through interviews with staff #124 and #125. The DOC stated that video surveillance confirmed that staff #122 used threatening and intimidating actions towards resident #027. The staff member was terminated. The home failed to ensure that resident #027 was protected from emotional abuse by anyone. [s. 19. (1)] (682)

This area of non-compliance was identified during a CIS inspection, log #027054-17 conducted concurrently during this RQI. [s. 19. (1)]

Additional Required Actions:

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

WN #2: 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 residents were assessed and his or her bed system evaluated in accordance with prevailing practices, to minimize risk to the residents.

The prevailing practices have been identified by the Ministry of Health and Long Term Care in 2012, to include guidelines developed by Health Canada (HC) entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. Within this document, two additional companion guides are

identified, one in particular specifically related to resident assessments entitled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada).

Bed System Evaluations

The HC guideline provides recommendations relating to bed systems and bed accessories in order to reduce life threatening entrapments associated with adult hospital bed systems. It characterizes the body parts at risk for entrapment, identifies the locations of bed openings that are potential entrapment areas, and recommends dimensional criteria for bed rails. In addition, the HC guide provides guidance with measuring bed systems with a weighted cone and cylinder tool to identify whether any of the four identified entrapment zones fail the dimensional criteria. The four entrapment zones are within the bed rail and areas between the mattress and the bed rail.

During the inspection, inspector #611 observed a particular type of bed rail approximately tucked under a mattress on the side of resident #009's bed. The bed also included bed rails attached to the frame. The identified bed rail was not an approved bed rail in that it was not purchased from the bed system manufacturer, but from a retail outlet for domestic use. Based on the design of the bed rail, the inspector believed it failed zone one, an entrapment zone between the bars. When the ESS was asked to verify the status of the identified bed rail, it did not pass the HC dimensional criteria for zone one when measured with a specialized tool designed to measure gaps in and around bed rails. The ESS, who was new in their position, was not aware of the identified bed rail. The bed rail was removed after it was brought to the home's attention and the resident received a different bed system. According to PSW #101, the resident brought the identified bed rail into the home on their date of admission. According to the RAI-MDS co-ordinator, the nursing staff left the bed rail in place and included its use in the resident's plan of care. When the licensee re-developed their bed safety program and re-assessed residents for risks related to bed rail use beginning in January 2018, the resident's identified bed rail was not removed, and instead, the resident was provided a "Bed Safety Waiver" to sign, identifying that the resident made the decision to continue to use the bed rail against the advice of the registered staff and team.

When the resident's bed system was evaluated in 2017, the documentation revealed that only another type of bed rail was measured and passed all four zones of entrapment. The identified bed rail was never evaluated for safety and entrapment risks and the

licensee's bed safety policies did not include any direction for staff regarding the use of assistive devices that were not purchased from the bed manufacturer.

Resident Assessments

The clinical guidance companion guide provides the necessary guidance in establishing a clinical assessment where bed rails are used. It is currently the most comprehensive and available guide. Although the authors of the clinical guidance document identified that the recommendations were not intended to serve as applicable regulations or guidelines governing care in respective settings and that they should not be interpreted as the best or only options, professional standards of care, or legal protection for the users, the clinical guidance document has been written deliberately to be basic in design and content to allow each setting to adapt it to meet the unique needs of their respective residents and environments. The clinical guide has been adopted as part of the regulatory requirement under this section to ensure that residents are assessed and that steps are taken to prevent entrapment and that safety hazards are addressed and risks minimized. A key principle in the document includes that the resident's right to participate in care planning and make choices should be balanced with caregivers' responsibility to provide care according to an individual assessment, professional standards of care, and any applicable laws and regulations.

During the inspection, three residents (#009, #011, #012) were selected to determine whether they were assessed for bed rail use, whether alternatives were trialled before bed rails were applied, whether the resident was assessed for bed rail-related safety risks once they were applied and what interventions were implemented to mitigate the risks (if any).

Resident #009, who was not observed in bed at the time of inspection, but according to Inspector #611 the resident had an identified type of bed rail on their bed (which failed zone one) and a care plan requiring its use. Both PSW #101 and the RAI-MDS Co-ordinator verified that the resident arrived to the home with the identified rail and was used by the resident on their left side. The resident had a bed safety assessment completed upon admission and again later that year. On both assessments, the assessor answered questions regarding the bed rail entrapment status as having passed all four zones of entrapment. Neither assessment identified the identified bed rail was in use. A review of the progress notes made by registered staff between within a seven month period did not include any information about the resident having brought in their own identified type of bed rail and what if any safety risks were associated with its use. A

more comprehensive revised assessment was completed in 2018 that identified that the resident had one bed-related safety risk factor (related to mobility). The assessment did not include the question related to the entrapment status of the bed rails and included the use of different rails on the bed. Newly added, the assessment included a question as to whether the resident was monitored over a 72-hour period when in bed sleeping but did not include when the sleep study was conducted or a conclusion or analysis of the results of the sleep study. No alternative devices to using the identified or other bed rails were documented as trialled. The DOC confirmed that the information related to the sleep study was documented on a separate form by various staff members and was required to be reviewed by the registered staff at the time they completed the bed safety assessment form. However, according to the DOC, the last sleep study information that was retrieved included no safety risk issues identified as the resident slept calmly during the sleep study period. No bed safety assessment from 2018 could be located. Based on the various bed safety assessments, the resident's bed system was not accurately reflected for entrapment risk, size of bed rail or what side the bed rails were on. Alternative assistive devices were not attempted with the resident and the potential risk factor identified in 2018 was waived by the licensee when the resident signed the "Bed Safety Waiver".

Resident #011 was observed in bed on two occasions during the inspection with bed rails in use. The resident's plan of care included the application of rails. The resident's bed safety assessment was not fully completed. The "resident risk" section was blank and therefore did not conclude what risk factors the resident had with respect to bed related injury or entrapment. The form included a question for the assessor to select whether the resident was monitored and observed in bed during a 72 hour sleep observation, but did not include the dates of the sleep study period or any conclusions. The results were captured on a separate document according to the DOC. The document included questions related to how the resident slept (sleeping, clam, restless, attempted to get out of bed, involuntary movements, not in bed, slept on edge of bed, able to reposition self in bed). The resident was observed throughout two periods of time in 2018, and was observed to have moved themselves side to side. The bed safety assessment form did not include what size and type of bed rails would be used and considered most appropriate for the resident's condition. The assessor documented that no alternatives to bed rails (assistive devices) were trialled and did not provide a reason why. At the end of the form, the assessor selected that the resident requested the bed rails. The risk over the benefit of bed rail use was not established.

Resident #012 was observed in bed during the inspection with bed rails in use. The

resident's plan of care included staff assistance for repositioning and the use of one of the bed rails. The resident's bed safety assessment was not fully completed. The "resident risk" section was blank and therefore did not conclude what risk factors the resident had with respect to bed related injury or entrapment. The form included a question for the assessor to select whether the resident was monitored and observed in bed during a 72 hour sleep observation, but did not include the dates of the sleep study or any conclusions. The results were captured on a separate document according to the DOC. The resident was observed on identified date in 2018 and was observed to have gotten out of bed throughout the night. The assessor documented that no alternatives to bed rails (assistive devices) were trialled and did not provide a reason why. The risk over the benefit of bed rail use was not established.

According to the licensee's policy entitled "Bed Safety Assessment" (LTC-CA-ON-200-07 -22 revised January 2018), reference was made to the use of the "Bed Safety Program Waiver" for either resident or SDM if they "insisted on using bed rails contrary to the indications of the assessment and recommendations of the team, that registered staff will provide a waiver for release of responsibility". The policy included a note on page 5 that "bed rails should only be used when all other alternatives have been shown to be ineffective with respect to addressing the resident's needs". No further details were provided to guide the assessor in the policy in regard to addressing the identified risks when bed rails were applied, if alternatives were deemed to be ineffective.

Discussion was held with the Administrator that a signed waiver releasing them from their obligations to ensure a safe bed system could not be accepted. The licensee was responsible for managing any identified risks with respect to their equipment and for pursuing the use of alternatives. The regulatory requirement for medical devices such as bed rails, [which are also considered personal assistance services devices] is that the devices be applied when the benefit outweighed the risk, that it is appropriate for the resident's condition, that consent be obtained when the interdisciplinary team decided that the resident's condition warranted a bed rail and that bed rails were necessary to assist the resident with an activity such as bed mobility or transfers. [s. 15. (1) (a)]

2. The licensee failed to ensure that other safety issues related to the use of bed rails were addressed, including height and latch reliability.

During a tour of the home several bed systems were noted to have loose bed rails. The bed rails were designed to rotate 180 degrees and locked into two separate positions, in the transfer position (vertical) or the guard position (horizontal). The bed rail could also

be rotated back until a part of it hit the floor and was almost level with the mattress. When the bed rails were tested for stability and function, the bed rails were very loose, offering no stability for the resident using it to get out of bed while in the transfer position and opening up a wider space between the bed rail and mattress, a potential zone of entrapment.

During the tour, the rotating assist bed rails for resident #009 were found by LTCH Inspector #120 to be loose and the condition was reported to the ESS. Upon inspection, the metal mounting plate that was attached to the frame was noted to be loosely attached, allowing the bed rails to wiggle back and forth and away from the side of the mattress. The attachment was designed in such a manner as to prevent any tightening. The ESS added additional hardware to secure the metal plate on the same date, and the bed rails were confirmed to be more secure.

Resident #012 was observed in bed with bed rails in place. The resident's plan of care included the use of the bed rails. Both bed rails were very loose, causing a gap to open up between the mattress and bed rail.

Resident #014, although not observed in bed during the inspection, had a plan of care requiring the use of both bed rails when in bed. Both bed rails were very loose when checked.

The licensee's "Bed Safety Assessment" policy dated January 2018, included direction that "care staff will monitor the use of bed rails and report any observation or issues to registered staff and involved examining any changes to the bed system" and "any staff noticing a mechanical issue with a bed rail is to notify the registered staff immediately as well as maintenance of what was observed". The maintenance log, located at the nurse's station for staff use, did not include any entries related to the beds identified with loose bed rails. The beds for resident #012 and #014 were reported to the ESS and Administrator by the LTCH Inspector, both of whom were unaware of the loose condition of the bed rails and who both stated that it was an expectation for staff (housekeepers, PSWs and nursing staff) to report bed rails that were not stable. The ESS reported that the other bed rails would be checked to determine how many others were designed with the same type of mounting plate and would be rectified.

The licensee therefore did not ensure that other safety issues related to the use of bed rails were addressed. [s. 15. (1) (c)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee did not ensure that all staff used equipment in the home in accordance with manufacturers' instructions.

On an identified date in 2018, two PSWs transferred resident #008 using a specified transferring mechanism. During the transfer process, the resident sustained an injury and was transferred to hospital for treatment. According to the DOC, who conducted an evaluation of the incident, PSW #102 did not use the transferring mechanism appropriately.

PSW #102 confirmed to inspector #120 that they had failed to ensure the transferring mechanism was used appropriate to ensure safety. The directions for appropriate use was confirmed through review of the manufacturer's user manual.

The licensee failed to ensure that all staff used equipment in the home in accordance with manufacturers' instructions. [s. 23.]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

Through complaint intake log #023582-17, resident #010's family member voiced concern around the resident's medication administration as per their plan of care.

Review of the resident's electronic and paper health records did not include any direction to staff regarding the area of concern.

In an interview with registered staff #105 they indicated that the resident did require a certain intervention for medication administration. When asked where this information was located, the staff member indicated that this was written on each resident's specific drawer located in the medication cart. Upon review with the staff member, it was identified that resident #010 did not have a label on their drawer. Staff #105 confirmed that the label was missing for the resident and there was no information directing staff to on the certain intervention for medication administration. The home did not ensure that resident #010's plan of care included the planned care for the resident. [s. 6. (1) (a)]

2. The licensee failed to ensure that there was a written plan of care for each resident that set out clear directions to staff and others who provided direct care to the resident.

A. During observations, resident #004 was lying in their bed. There were two bed rails in place. A clinical record review including a bed system assessment indicated that resident had only one bed rail and it was a different length than what was observed.

The current care plan indicated that resident #004 only had one bed rail. The logo observed above the bed indicated that resident #004 was to have one bed rail during the day and at night.

During an interview with staff #116 they confirmed that the logo above the bed indicated that resident was to have one bed rail up while in bed and that there was no information included for the other side. The staff confirmed that the other bed rail was in position and could not explain why it was part of resident's #004 bed system. During an interview, staff #106 stated that resident #004 only had one bed rail included in their plan of care and that resident #004 bed system reassessment was not accurate.

The home failed to ensure that resident's #004 written plan of care set out clear directions to staff who provide direct care to the resident. (682).

B. Resident #011 was observed in bed on two occasions with two bed rails in place. The logo above their bed identified that both bed rails required to be "engaged" at all times and no information about what position they needed to be in. The resident's bed safety assessment did not include what size bed rails would be used. The resident's plan of care included that the resident required staff assistance with positioning and the application of only one rail. The information between the various sources of the resident's care plan were inconsistent, thereby unclear to staff who were required to apply bed rails for the resident while in bed. [s. 6. (1) (c)]

3. The licensee failed to ensure that every resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed or the care set out in the plan was no longer necessary.

On an identified date in 2018 the home submitted a CIS report #2922-000009-18, in which resident #012 touched resident #029 inappropriately.

Due to this, the home implemented an intervention that the resident was to sit at another table in the dining room. This was added to their documented plan of care. There had been no further incidents since that time.

Observation of the resident in the dining room identified that they were seated at another table which went against what was listed in their plan of care. The home's seating chart identified that the resident regularly sat at a table.

In an interview with staff #127 they indicated that this was no longer a requirement for the resident. In an interview with the DOC they confirmed that this was no longer necessary and indicated that the resident's plan of care had not been updated when their care needs changed.

This area of non-compliance was identified during CIS inspection, log #002949-18, conducted concurrently with this RQI. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that set out the planned care for the resident; to ensure there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; and, to ensure that every resident is reassessed and the plan of care reviewed and revised when the resident's care needs change or the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, (f) clearly indicated when activated where the signal was coming from.

The long term care home, when approved to occupy the building in 2004, was equipped with a resident-staff communication and response system that included a component that required staff to wear pagers. The pagers provided an audio and visual signal to alert the staff wearing them as to when one or more pull stations were activated and when any door system was breached, and the location of the activated station or door security breach. Activation stations were located in every resident room, washroom, bathing rooms and common spaces for staff, resident or visitor use.

During the inspection, a resident activated their station at 1042 hours. as PSW #101 was on break and another PSW was in another resident's room. After three minutes, PSW #102 responded to the call for assistance. When asked if they had a pager, the PSW said no, that they had not had pagers for at least a couple of months. A registered nurse and several PSWs on the third and second floor identified that they had not carried a pager for a number of months and that they were inconsistently functioning and unreliable when they did. The ESS reported that the pagers had not been in use for

many months due to a larger system malfunction. Repairs to the system had not been initiated.

The system that was in place during the inspection included the required lights next to each room or space equipped with an activation station. The lights were flat against the walls and quite small and difficult to see if one stood at one end of the corridor. If standing in one corridor, the lights could not be seen in the other corridor. A secondary visual display (marquee) was installed, that included scrolling digital data with the room number or name of the space activated. The marquee was also designed to sound when a station was activated by any person, and sounded (chimed) once every 60 seconds. The marquee was located in front of each of the nurse's stations for each of the five home areas. Each nurse's station was located in a corner where two corridors intersected. The marquee was located on the ceiling of the two intersecting corridors, but could not be seen by staff working in either corridor, unless they were at the nurse's station.

Without pagers, the system was incomplete and did not function as it was intended, which was to provide staff with immediate and clear information as to the location of an activated station or door security breach. The staff, if they were in a resident's room, were not able to determine how many stations or door breaches were activated and their exact location. The location could only be obtained by walking out of the room and down the corridor to the nurse's station to observe the digital data scrolling across the marquee. In addition, although two points of sound were installed (at the marquee and at the mid-point of each corridor), the sound was very low and could not be heard well while in certain resident rooms located at the end of each corridor. [s. 17. (1) (f)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is equipped with a resident-staff communication and response system that, (f) clearly indicates when activated where the signal is coming from, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

A review of the licensee's policy, "Abuse Allegations and Follow up" Policy No: LTC-CA-WQ-100-05-02, revised July, 2016, indicated:
"Allegations of abuse immediate action; When a staff member receives a report of abuse or observes anyone (another staff member, volunteer, family member, visitors or residents) abusing a resident in any manner, staff will: separate the resident and alleged abuser; staff are to take the resident to a quiet and safe location and have another staff member stay with them. Direct the alleged abuser to an isolated location. Ensure safety - Immediately report the allegation to the ADM/DOC or building supervisor following the internal reporting system for incident management".

On an identified date in 2017, the home submitted a CIS #2922-000026-17, which indicated that staff #122 allegedly physically abused and was rough with resident #027. No injuries to resident #027 were noted. A review of the investigative notes revealed that the incident was not reported until the following shift. During an interview, staff #124 stated they reported the witnessed alleged abuse of resident #027 to staff #123 at the time of the incident. Staff #125 also stated that they did not intervene and separate the resident from the alleged abuser at the time of the incident. During an interview, staff #123 denied being informed of the incident until they arrived for their shift the following day and subsequently reported the alleged abuse. During an interview, the DOC stated that the staff did not immediately report or intervene and assess the resident at the time of the incident. The home failed to ensure that the written policy to promote zero tolerance of abuse and neglect of resident #027 was complied with.

This area of non-compliance was identified during a CIS inspection, log #027054-17 conducted concurrently with this RQI. [s. 20. (1)]

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A review of the clinical health record, indicated as part of the admission orders, that resident #015 was to receive a specified medication. The homes pharmacy provider entered the order into the electronic Medication Admission Record (eMAR) incorrectly.

This medication incident was not immediately discovered and resident #015 received the incorrect dosage of the medication for one month. In an interview with registered staff #119, it was confirmed that the medication incident was discovered after the resident was administered the incorrect dosage for one month.

In an interview with registered staff #119, and the DOC it was confirmed that this resident did not receive this medication in accordance with directions for use specified by the prescriber. [s. 131. (2)]

Issued on this 13th day of August, 2018

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA PALADINO (586), AILEEN GRABA (682), BERNADETTE SUSNIK (120), KELLY CHUCKRY (611)
Inspection No. / No de l'inspection :	2018_689586_0017
Log No. / No de registre :	014915-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Aug 13, 2018
Licensee / Titulaire de permis :	Liuna Local 837 Nursing Home (Ancaster) Corporation 44 Hughson Street South, HAMILTON, ON, L8N-2A7
LTC Home / Foyer de SLD :	Regina Gardens 536 Upper Paradise Road, HAMILTON, ON, L9C-5E3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Candace Lanthier

To Liuna Local 837 Nursing Home (Ancaster) Corporation, 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 :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with LTCHA s. 19 (1).

Specifically the licensee shall ensure resident #027, and all other residents, are protected from emotional and physical abuse by anyone.

Grounds / Motifs :

1. The licensee failed to ensure that all residents were protected from abuse by anyone.

O.Reg. 79/10, s. 2 (1) defines emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident,

On an identified date in 2017, the home submitted a CIS report #2922-000026-17, which indicated that staff #122 allegedly physically abused and was rough with resident #027. No injuries to resident #027 were noted.

A review of resident #027's clinical record was completed. Investigative notes indicated that on staff #123 reported to the home's management that staff #124 and #125 witnessed an incident of alleged abuse of staff #122 toward resident #027. This was confirmed through interviews with staff #124 and #125. The DOC stated that video surveillance confirmed that staff #122 used threatening and intimidating actions towards resident #027. The staff member was terminated. The home failed to ensure that resident #027 was protected from emotional abuse by anyone. [s. 19. (1)] (682)

This area of non-compliance was identified during a CIS inspection, log #027054 -17 conducted concurrently during this RQI. (682)

2. The licensee failed to ensure that all residents were protected from abuse by anyone. O. Reg. 79/10, s. 2 (1) defines physical abuse as the use of physical force by anyone other than a resident that causes physical injury or pain.

On an identified date in 2017, the home submitted a CIS report #2922-000015-17, in which staff #121 witnessed resident #019 approach staff #120 and accuse them of causing an injury during care. Staff #121 reported this to staff #117, who then assessed the resident.

In an interview with staff #117 on an identified date in 2018, the staff member indicated that when they spoke with the resident after the incident, the resident told them that staff #120 had injured them.

A skin assessment completed after the incident and identified an area of altered skin integrity.

A review of the home's internal investigation notes, as well as interview with staff #117, confirmed that the area of altered skin integrity was not present prior to the incident.

In an interview with the DOC, they confirmed that the home's internal investigation determined that staff #120 caused the injury during care. The resident was upset by the incident. The staff member was terminated. The DOC confirmed that the findings of the investigation concluded that resident #019 was not protected from physical abuse by staff #120.

This area of non-compliance was identified during a CIS inspection, log #011615 -17 conducted concurrently during this RQI.

The severity of this issue was determined to be a level 3 as there was actual harm and risk to the resident. The scope of the issue was a level 1 as it related to one of ten residents reviewed. The home had a level of 2 history as they had ongoing non-compliance in unrelated areas. (586)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2018

Order # / Ordre no : 002

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

Specifically, the licensee must:

1. Fully complete the bed safety assessments for residents #011 and #012, including;
a) why alternatives were not trialled before bed rails were applied; and
b) a conclusion of the results of the sleep observation period; and
c) a risk over benefit statement as to why bed rails are or are not appropriate based on the resident's risk factors and actual risks.

2. Complete an audit of all bed systems for bed rail stability and if any are found to be unstable (wobbly, loose, bent), the condition of the bed rail(s) shall be rectified.

3. All health care staff and housekeeping staff shall be re-educated on the licensee's "Bed Safety Assessment" policy dated January 2018, regarding the requirement to monitor the use of bed rails and to report any mechanical issues to registered staff.

Grounds / Motifs :

1. The licensee failed to ensure that where bed rails were used, that the residents were assessed and his or her bed system evaluated in accordance with prevailing practices, to minimize risk to the residents.

The prevailing practices have been identified by the Ministry of Health and Long Term Care in 2012, to include guidelines developed by Health Canada (HC) entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. Within this document, two additional companion guides are identified, one in particular specifically related to resident assessments entitled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings, 2003" (developed by the US Food and Drug Administration and adopted by Health Canada).

Bed System Evaluations

The HC guideline provides recommendations relating to bed systems and bed accessories in order to reduce life threatening entrapments associated with adult hospital bed systems. It characterizes the body parts at risk for entrapment, identifies the locations of bed openings that are potential entrapment areas, and recommends dimensional criteria for bed rails. In addition, the HC guide provides guidance with measuring bed systems with a weighted cone and cylinder tool to identify whether any of the four identified entrapment zones fail the dimensional criteria. The four entrapment zones are within the bed rail and areas between the mattress and the bed rail.

During the inspection, inspector #611 observed a particular type of bed rail approximately tucked under a mattress on the side of resident #009's bed. The bed also included bed rails attached to the frame. The identified bed rail was not an approved bed rail in that it was not purchased from the bed system manufacturer, but from a retail outlet for domestic use. Based on the design of the bed rail, the inspector believed it failed zone one, an entrapment zone between the bars. When the ESS was asked to verify the status of the identified bed rail, it did not pass the HC dimensional criteria for zone one when measured with a specialized tool designed to measure gaps in and around bed rails. The ESS, who was new in their position, was not aware of the identified bed rail. The bed rail was removed after it was brought to the home's attention and the resident received a different bed system. According to PSW #101, the resident brought the identified bed rail into the home on their date of admission.

According to the RAI-MDS co-ordinator, the nursing staff left the bed rail in place and included its use in the resident's plan of care. When the licensee re-developed their bed safety program and re-assessed residents for risks related to bed rail use beginning in January 2018, the resident's identified bed rail was not removed, and instead, the resident was provided a "Bed Safety Waiver" to sign, identifying that the resident made the decision to continue to use the bed rail against the advice of the registered staff and team.

When the resident's bed system was evaluated in 2017, the documentation revealed that only another type of bed rail was measured and passed all four zones of entrapment. The identified bed rail was never evaluated for safety and entrapment risks and the licensee's bed safety policies did not include any direction for staff regarding the use of assistive devices that were not purchased from the bed manufacturer.

Resident Assessments

The clinical guidance companion guide provides the necessary guidance in establishing a clinical assessment where bed rails are used. It is currently the most comprehensive and available guide. Although the authors of the clinical guidance document identified that the recommendations were not intended to serve as applicable regulations or guidelines governing care in respective settings and that they should not be interpreted as the best or only options, professional standards of care, or legal protection for the users, the clinical guidance document has been written deliberately to be basic in design and content to allow each setting to adapt it to meet the unique needs of their respective residents and environments. The clinical guide has been adopted as part of the regulatory requirement under this section to ensure that residents are assessed and that steps are taken to prevent entrapment and that safety hazards are addressed and risks minimized. A key principle in the document includes that the resident's right to participate in care planning and make choices should be balanced with caregivers' responsibility to provide care according to an individual assessment, professional standards of care, and any applicable laws and regulations.

During the inspection, three residents (#009, #011, #012) were selected to determine whether they were assessed for bed rail use, whether alternatives were trialled before bed rails were applied, whether the resident was assessed

for bed rail-related safety risks once they were applied and what interventions were implemented to mitigate the risks (if any).

Resident #009, who was not observed in bed at the time of inspection, but according to Inspector #611 the resident had an identified type of bed rail on their bed (which failed zone one) and a care plan requiring its use. Both PSW #101 and the RAI-MDS Co-ordinator verified that the resident arrived to the home with the identified rail and was used by the resident on their left side. The resident had a bed safety assessment completed upon admission and again later that year. On both assessments, the assessor answered questions regarding the bed rail entrapment status as having passed all four zones of entrapment. Neither assessment identified the identified bed rail was in use. A review of the progress notes made by registered staff between within a seven month period did not include any information about the resident having brought in their own identified type of bed rail and what if any safety risks were associated with its use. A more comprehensive revised assessment was completed in 2018 that identified that the resident had one bed-related safety risk factor (related to mobility). The assessment did not include the question related to the entrapment status of the bed rails and included the use of different rails on the bed. Newly added, the assessment included a question as to whether the resident was monitored over a 72-hour period when in bed sleeping but did not include when the sleep study was conducted or a conclusion or analysis of the results of the sleep study. No alternative devices to using the identified or other bed rails were documented as trialled. The DOC confirmed that the information related to the sleep study was documented on a separate form by various staff members and was required to be reviewed by the registered staff at the time they completed the bed safety assessment form. However, according to the DOC, the last sleep study information that was retrieved included no safety risk issues identified as the resident slept calmly during the sleep study period. No bed safety assessment from 2018 could be located. Based on the various bed safety assessments, the resident's bed system was not accurately reflected for entrapment risk, size of bed rail or what side the bed rails were on. Alternative assistive devices were not attempted with the resident and the potential risk factor identified in 2018 was waived by the licensee when the resident signed the "Bed Safety Waiver".

Resident #011 was observed in bed on two occasions during the inspection with bed rails in use. The resident's plan of care included the application of rails. The resident's bed safety assessment was not fully completed. The "resident

risk" section was blank and therefore did not conclude what risk factors the resident had with respect to bed related injury or entrapment. The form included a question for the assessor to select whether the resident was monitored and observed in bed during a 72 hour sleep observation, but did not include the dates of the sleep study period or any conclusions. The results were captured on a separate document according to the DOC. The document included questions related to how the resident slept (sleeping, clam, restless, attempted to get out of bed, involuntary movements, not in bed, slept on edge of bed, able to reposition self in bed). The resident was observed throughout two periods of time in 2018, and was observed to have moved themselves side to side. The bed safety assessment form did not include what size and type of bed rails would be used and considered most appropriate for the resident's condition. The assessor documented that no alternatives to bed rails (assistive devices) were trialled and did not provide a reason why. At the end of the form, the assessor selected that the resident requested the bed rails. The risk over the benefit of bed rail use was not established.

Resident #012 was observed in bed during the inspection with bed rails in use. The resident's plan of care included staff assistance for repositioning and the use of one of the bed rails. The resident's bed safety assessment was not fully completed. The "resident risk" section was blank and therefore did not conclude what risk factors the resident had with respect to bed related injury or entrapment. The form included a question for the assessor to select whether the resident was monitored and observed in bed during a 72 hour sleep observation, but did not include the dates of the sleep study or any conclusions. The results were captured on a separate document according to the DOC. The resident was observed on identified date in 2018 and was observed to have gotten out of bed throughout the night. The assessor documented that no alternatives to bed rails (assistive devices) were trialled and did not provide a reason why. The risk over the benefit of bed rail use was not established.

According to the licensee's policy entitled "Bed Safety Assessment" (LTC-CA-ON-200-07-22 revised January 2018), reference was made to the use of the "Bed Safety Program Waiver" for either resident or SDM if they "insisted on using bed rails contrary to the indications of the assessment and recommendations of the team, that registered staff will provide a waiver for release of responsibility". The policy included a note on page 5 that "bed rails should only be used when all other alternatives have been shown to be ineffective with respect to addressing the resident's needs". No further details

were provided to guide the assessor in the policy in regard to addressing the identified risks when bed rails were applied, if alternatives were deemed to be ineffective.

Discussion was held with the Administrator that a signed waiver releasing them from their obligations to ensure a safe bed system could not be accepted. The licensee was responsible for managing any identified risks with respect to their equipment and for pursuing the use of alternatives. The regulatory requirement for medical devices such as bed rails, [which are also considered personal assistance services devices] is that the devices be applied when the benefit outweighed the risk, that it is appropriate for the resident's condition, that consent be obtained when the interdisciplinary team decided that the resident's condition warranted a bed rail and that bed rails were necessary to assist the resident with an activity such as bed mobility or transfers. (120)

2. The licensee failed to ensure that other safety issues related to the use of bed rails were addressed, including height and latch reliability.

During a tour of the home several bed systems were noted to have loose bed rails. The bed rails were designed to rotate 180 degrees and locked into two separate positions, in the transfer position (vertical) or the guard position (horizontal). The bed rail could also be rotated back until a part of it hit the floor and was almost level with the mattress. When the bed rails were tested for stability and function, the bed rails were very loose, offering no stability for the resident using it to get out of bed while in the transfer position and opening up a wider space between the bed rail and mattress, a potential zone of entrapment.

During the tour, the rotating assist bed rails for resident #009 were found by LTCH Inspector #120 to be loose and the condition was reported to the ESS. Upon inspection, the metal mounting plate that was attached to the frame was noted to be loosely attached, allowing the bed rails to wiggle back and forth and away from the side of the mattress. The attachment was designed in such a manner as to prevent any tightening. The ESS added additional hardware to secure the metal plate on the same date, and the bed rails were confirmed to be more secure.

Resident #012 was observed in bed with bed rails in place. The resident's plan of care included the use of the bed rails. Both bed rails were very loose, causing a gap to open up between the mattress and bed rail.

Resident #014, although not observed in bed during the inspection, had a plan of care requiring the use of both bed rails when in bed. Both bed rails were very loose when checked.

The licensee's "Bed Safety Assessment" policy dated January 2018, included direction that "care staff will monitor the use of bed rails and report any observation or issues to registered staff and involved examining any changes to the bed system" and "any staff noticing a mechanical issue with a bed rail is to notify the registered staff immediately as well as maintenance of what was observed". The maintenance log, located at the nurse's station for staff use, did not include any entries related to the beds identified with loose bed rails. The beds for resident #012 and #014 were reported to the ESS and Administrator by the LTCH Inspector, both of whom were unaware of the loose condition of the bed rails and who both stated that it was an expectation for staff (housekeepers, PSWs and nursing staff) to report bed rails that were not stable. The ESS reported that the other bed rails would be checked to determine how many others were designed with the same type of mounting plate and would be rectified.

The licensee therefore did not ensure that other safety issues related to the use of bed rails were addressed.

The severity of this issue was determined to be a level 2 as there was potential harm to the residents. The scope of the issue was a level 3 as it was widespread throughout the home. The home had a level of 2 history as they had ongoing non-compliance in unrelated areas. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2018

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 : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Order / Ordre :

The licensee must be compliant with O. Reg 79/10, s. 23.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that staff #102 uses the identified transferring mechanism in accordance with manufacturers' instructions when transferring resident #008, and any other resident requiring its use.

Please submit the written plan, inspection #2018_689586_0017 to Bernadette Susnik, LTC Inspector, MOHLTC, by e-mail to HamiltonHSAO.moh@ontario.ca.

Grounds / Motifs :

1. The licensee did not ensure that all staff used equipment in the home in accordance with manufacturers' instructions.

On an identified date in 2018, two PSWs transferred resident #008 using a specified transferring mechanism. During the transfer process, the resident sustained an injury and was transferred to hospital for treatment. According to the DOC, who conducted an evaluation of the incident, PSW #102 did not use the transferring mechanism appropriately.

PSW #102 confirmed to inspector #120 that they had failed to ensure the transferring mechanism was used appropriate to ensure safety. The directions for appropriate use was confirmed through review of the manufacturer's user manual.

The licensee failed to ensure that all staff used equipment in the home in accordance with manufacturers' instructions. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 05, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this (these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

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 RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON 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

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

Issued on this 13th day of August, 2018

Signature of Inspector /
Signature de l'inspecteur :

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

Name of Inspector / Nom de l'inspecteur : Jessica Paladino

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