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 # / No de registre	Type of Inspection / Genre d'inspection
Jan 16, 2018	2017_625133_0019	009017-17	Follow up

Licensee/Titulaire de permis

ST. PATRICK'S HOME OF OTTAWA INC.
2865 Riverside Dr. OTTAWA ON K1V 8N5

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

ST PATRICK'S HOME
2865 RIVERSIDE DRIVE OTTAWA ON K1V 8N5

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

JESSICA LAPENSEE (133)

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): November 28, 29, 30, December 1, 5, 2017

This inspection was in follow up to a compliance order related to bed rail use. The compliance order is reissued as a result of this inspection.

During the course of the inspection, the inspector(s) spoke with the President and Chief Executive Officer, the Vice President of Nursing, the Assistant Vice President of Nursing, the Vice President of Building Operations, maintenance workers, a housekeeping worker, registered and non registered nursing staff and a resident.

During the course of the inspection, the Inspector observed residents' bed systems and reviewed the resident bedrail assessment tool titled " Bedrail and Entrapment Risk Assessment - V2", bed system evaluation related documentation and identified resident's health care records.

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that, where bed rails are used, 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.

On April 13, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Critical Incident System Inspection #2017_617148_0014. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by August 4, 2017.

Part 1 of the compliance order was related to residents' bed systems and parts 2 to 4 of the compliance order were related to the assessment of residents.

In relation to residents' bed systems:

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed

openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools (cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

On November 24, 2017, the Chief Executive Officer (CEO) provided the Inspector with the bed system information binder, which contained the results of all of the bed system evaluations that had been conducted in response to part 1 of the compliance order. The CEO indicated that there were three staff members (#113, #114, #115) trained to conduct bed system evaluations, two of which (#113, #115) had conducted all of the bed system evaluations in response to the compliance order. It was indicated that all bed systems that had been evaluated had passed.

As per the bed system information binder, maintenance worker #113 had conducted all of the bed system evaluations on six of the nine care units and some of the bed system evaluations on two of the remaining three care units. Maintenance worker #115 had conducted all of the bed system evaluations on one of the nine care units and some on two of the nine care units. The CEO indicated that housekeeping worker # 114 had conducted the subsequent bed system evaluations.

On November 24, 2017, the Inspector observed resident #006, #007 and #008's bed systems and noted that these and bed systems throughout the care unit were of the same type. As per the information contained in the bed system information binder, it was noted that resident #006, #007 and #008's bed systems were given a "pass". The Inspector observed that the bed rails on resident #006 - #008's bed systems were loose and that there was a gap of approximately 1 ½ inches to 1 ¾ inches between the inside surface of the rails and the edge of the mattress (without compression). This area is known as Zone 3, as per the HC guidance document, and presents a risk of entrapment of a resident's head. This gap lead the Inspector to request a demonstration of a bed system evaluation, as zone 3 would be vulnerable to failure depending on the compressibility of the mattress in place on the bed system, given the observed gap and degree of play with the rails. The zone 3 test requires that the cone (not attached to the cylinder) be placed horizontally in the gap between the bed rail and the mattress. The cone is to be allowed to sink into the space by its own weight. If the cone's center line is at or below the top surface of the mattress, the space fails the test.

On November 24, 2017, housekeeping worker #114 accompanied the Inspector to resident #006's bedroom, with the testing tool as prescribed by the HC guidance

document. The Inspector requested that the housekeeping worker conduct an evaluation of resident #006's bed system. The process demonstrated was not in accordance with the testing prescribed by the HC guidance document. Housekeeping worker #114 was unable to demonstrate testing for zones 1 – 4 as per the HC guidance document and did not demonstrate knowledge of zones 1 - 4. The Inspector and the housekeeping worker reviewed the prescribed testing procedure for zones 1-4, as per the HC guidance document. Housekeeping worker #114 indicated that, for example, for zone 2 and 3, he was taught to use the fully assembled tool (cone and cylinder) and to place it in a way that the cone was between the rail and the mattress, then to observe if the cone sank down below the mattress. If the cone portion sank down below the mattress, then he would consider it as a fail. Housekeeping worker #114 indicated that he was not aware that the zone 2 and 3 test required use of the cone only and that the zone 2 test also required use of a scale, and required the cone to be inserted, small end first, into the gap between the mattress and the lower edge of the rail, between rail supports. Then, the scale is to be attached to the loop on the cone and the cone is to be pulled with 12 pounds of pressure at any angle that increases the chance of the cone going through the space. Related to zone 3, housekeeping worker #114 indicated that he had not been aware that if the cone's center line was at the surface of the mattress, after the cone had been allowed to compress the mattress, then zone 3 would be considered a "fail". Related to zone 4, housekeeping worker indicated he had never been taught to observe the level on the cylinder or to observe the green "pass" or red "fail" section. Housekeeping worker #114 proceeded to test zones 1 - 4, on the right side of the bed system. Zone 1 was tested and passed, due to the size of the openings within the perimeter of the rail. Zone 2 was tested and passed, due to the design of the bed deck, which prevented the small end of the cone from passing through the space under the rail, between the rail supports. Zone 3 was tested, and the cone's center line was slightly above the edge of the compressed mattress, which may be considered a borderline pass as per the HC guidance document. Zone 4 was tested, and it passed, as the cylinder touched the rail in the green section when held level and in the prescribed position. Housekeeping worker #114 indicated that he had been trained to conduct bed system evaluations by the Vice President (VP) of Building Operations.

On November 28, 2017, the VP of Building Operations indicated that when the bed system testing tool was received, he also received a video from the tool supplier. The VP of Building Operations indicated that he and maintenance worker #115 had watched the video in order to learn how to use the testing tool.

On November 28, 2017, maintenance worker #113 accompanied the Inspector to

resident #007's bedroom, with the testing tool as prescribed by the HC guidance document. The Inspector requested that the maintenance worker conduct an evaluation of resident #007's bed system. The process demonstrated was not in accordance with the testing prescribed by the HC guidance document. The maintenance worker was unable to demonstrate testing for zones 1 – 4 as per the HC guidance document and did not demonstrate knowledge of zones 1 – 4. For example, the maintenance worker positioned the cone horizontally in between the mattress and the rail and noted that the cone did not go down below the surface of the mattress. The maintenance worker then placed the cone on the mattress, pointing towards an opening in the rail and noted that the cone did not sink down into the mattress. The maintenance worker indicated that he would indicate a pass for zones 1, 2 and 3 given the tests he had conducted. The maintenance worker indicated that he was not aware that if the centre line of the cone was at the surface of the mattress, zone 3 would be considered a fail. The Inspector then requested that the maintenance worker contact the VP of Building Operations and request that he join the Inspector and the maintenance worker. Upon the arrival of the VP of Building Operations, the maintenance worker conducted what he indicated would be the final test, for zone 4, which was to position the small end of the cone down in between the edge of the mattress and the rail. As the large end of the cone did not go down below the mattress surface, the maintenance worker indicated it was a pass. The process demonstrated was the initial step in performing a zone 2 test, which is to include the use of a scale to pull the cone down. The VP of Building Operations indicated that it was maintenance worker # 115 who had begun the home wide bed system evaluation process in response to the compliance order. The VP of Building Operations indicated that maintenance worker #115 had found that due to the design of the bed systems in the home, the bed deck always prevented the large end of the cone from going down under the rail and therefore they stopped using the scale to attempt to pull the cone down. The VP of Building Operations indicated that maintenance worker #115 had also found that zone 4 passed on all bed systems he had evaluated, with the assembled tool (cone and cylinder), with use of the level and observation of the "pass" and "fail" zones on the cylinder. The VP of Building Operations indicated that zone 4 always passed as a result of the design of the rails, and therefore they stopped testing zone 4. The VP of Building Operations indicated that even with a softer mattress, zone 4 would always pass due to the design of the rails. Zones 1 – 4 were subsequently tested by maintenance worker #113 in the prescribed way and all zones passed.

On November 28, 2017, the Inspector met with maintenance worker #115. He indicated that he and the VP of Building Operations had watched a video in order to educate themselves about how to conduct a bed system evaluation. He indicated that he recalled

having done the zone 2 test with the scale, and the zone 4 test with the fully assembled tool with observation of the level. The maintenance worker indicated that due to the design of the bed decks and bed rails, zone 2 and 4 would always pass. Related to zone 3, the maintenance worker indicated he was having trouble recalling, however, he believed that if he had observed that the cone's center line was at the surface of the mattress he would have questioned it. Maintenance worker #115 indicated that he had questioned the results of the zone 3 test for mattresses with raised edges. The Inspector requested that the maintenance worker accompany the Inspector to a bedroom where there was such a mattress in use, with the testing tool.

On November 28, 2017, maintenance worker #115 and the Inspector observed resident #009's bed system. The mattress in place had highly compressible raised edges, along the full length of the bed rails. Maintenance worker #115 placed the cone horizontally in the gap between the mattress and the right bed rail and the cone sank down in between the raised edge and the rail readily. The same occurred on the left side. Maintenance worker indicated that in discussion with the VP of Building Operations, they had not considered this as a fail as the cone did not sink down below the level of the mattress beyond the raised edge. The HC guidance document was reviewed and zone 3 was discussed. Zone 3 is the space between the inside surface of the rail and the mattress compressed by the weight of a resident's head. Zone 3 presents the risk of entrapment of a resident's head. With a mattress with raised edges, such as the mattress in use for resident #009, zone 3 is raised when compared to mattresses without raised edges. Maintenance worker #115 indicated that he would now consider this as a fail. The Inspector and the maintenance worker proceeded to observe resident #010's bed system, which also had a mattress with raised edges. The bed rails were not in use for resident #010 and were tied down. The maintenance worker untied the bed rails and proceeded to test zone 3. It was again observed that zone 3 with such a mattress failed the testing process readily.

The VP of Building Operations and the Support Services Manager (SSM) were subsequently informed that the mattresses with raised edges failed zone 3. The VP of Building Operations and the SSM indicated they were not aware how many such mattresses were in use with bed rails in the home. The VP of Building Operations indicated they would work towards a solution.

On November 30, 2017, the VP of Nursing indicated that it had been determined that there were 47 residents with raised edge mattresses with bed rails in use. The VP of Nursing indicated that there were 28 new mattresses on order and more had been

ordered. The VP of Nursing indicated that the use of bed rails would be reconsidered for every resident and that bed rails would be tied down if they were not needed. The VP of Nursing indicated that if bed rails were needed, they would switch the raised edge mattresses with flat mattresses or implement the use of accessories such as gap fillers, to reduce the risk of entrapment related to zone 3. The VP of Nursing indicate that the first and second floor units were completed.

On December 1, 2017, the VP of Nursing indicated that for 13 of the 47 residents, the bed rails in use on the bed system which included a raised edge mattress had been tied down, or, accessories such as gap fillers had been put into use, to reduce the risk of entrapment. The VP of Nursing indicated that there were 34 residents remaining with raised edge mattresses and bed rails in use, with no interventions in place. The VP of Nursing indicated that these residents would be put on an enhanced monitoring program and that extra nursing staff would be brought in to allow for the enhanced monitoring.

On December 5, 2017, the VP of Nursing indicated that as a result of resident reassessments related to bed rail use, mattress switches and accessory use, there remained 11 residents with bed rails in use with a raised edge mattress that required enhanced monitoring. With three additional mattress changes planned for the day, the VP of Nursing indicated that there would be 8 residents remaining that required enhanced monitoring by the end of the day.

On December 5, 2017, the VP of Building Operations indicated that he had provided training related to bed system evaluation to maintenance worker #113, #115, housekeeping worker #114 (as previously referenced) and two additional staff members. The VP of Building Operations indicated that where raised edge mattresses were being switched out for flat mattresses, for residents with bed rails in use, the resulting new bed system was being evaluated.

In relation to resident assessment:

The previously referenced HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. 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 (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered and are specified. The process is to result in a documented risk benefit assessment, prior to the team's conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:

a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.

b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.

c) Comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident.

The 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On November 28, 2017, the Inspector met with the VP of Nursing to discuss the resident assessment process that she had developed with regards to bed rail use. The VP of Nursing indicated that residents who are supposed to have one or two bed rails in use would have had an assessment completed, and for those who are not supposed to have bed rails in use, the bed rails on the resident's bed would have been tied down. Looking at the new assessment, titled "Bedrail and Entrapment Risk Assessment – V2", the Inspector noted that it did not contain all factors, elements and conditions as outlined in the 2003 FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care settings". The home was specifically directed to develop an assessment process in accordance with the clinical guidance document in part 2 of the compliance order. Following discussion, the VP of Nursing indicated that she had not seen the clinical guidance document before this meeting. The VP of Nursing indicated that she had not referenced the compliance order

while she was working on the assessment process. The VP of Nursing indicated that she had known that she had to develop an assessment for residents related to bed rail use and that she had looked at what other long term care homes were doing with regards to such assessments.

The clinical guidance document outlines, for example, that an individual resident assessment is to be conducted by an interdisciplinary team and is to include: medical diagnosis, conditions, symptoms and/or behavioural symptoms; sleep habits; medication; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling, etc. The assessment process is to result in risk benefit assessment, as previously referenced in this report. In discussion with the VP of Nursing, on November 29, 2017, it was concluded that the assessment process that she had developed was focused on the individual resident's mobility, exclusively.

In reference to the consideration of alternatives to bed rail use, as per part 3 of the compliance order, on November 29, 2017, the VP of Nursing confirmed that the assessment process that she had developed did not result in the consideration of alternatives to bed rail use.

In reference to the residents' written plan of care, as per part 4 of the compliance order, on November 29, 2017, the VP of Nursing indicated that it was expected that if a resident had bed rails in use, it was expected that there would be an assessment within the resident's health care record, with an associated progress note, and details of the resident's use of bed rails within the resident's care plan.

Related to resident #001:

On November 28, 2017, resident #001 was observed in his/her bed with two bed rails up, and a mattress with raised edges. Personal Support Worker (PSW) #103 indicated that the bed rails were always up for resident #001. On November 29, 2017, PSW #S109 indicated that bed rails had been in use for resident #001 since his/her admission to the home. Resident #001 was admitted to the home on an identified day in 2017. The Inspector reviewed resident #001's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was located. The assessment, completed on the resident's admission day, indicated that bed rails were not required for resident #001. The resident's care plan did not include reference to the use of bed rails.

Related to resident #002:

On November 28, 2017, resident #002's bed system was observed to have two bed rails up, and a flat mattress. PSW #104 indicated that bed rails have been in use for resident #002 since his/her admission to the home and they are always up. Resident #002 was admitted to the home on an identified day in 2017. On November 29, 2017, PSW #111 indicated that bed rails are always up and in use for resident #002. The Inspector reviewed resident #002's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was not located. The resident's care plan did not include reference to the use of bed rails.

Related to resident #003:

On November 28, 2017, resident #003's bed system was observed to have two bed rails up, and a mattress with raised edges. RPN #112 indicated that bed rails were in use for resident #003. On November 29, 2017, PSW #105 indicated that bed rails have been in use for resident #003 since the resident's admission to the home. Resident #003 was admitted to the home on an identified day in 2017. The Inspector reviewed resident #003's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was not located. A progress note, made on the resident's admission day, indicated that bed rails were not required for resident #003. The resident's care plan did not include reference to the use of bed rails.

Related to resident #004:

On November 28, 2017, resident #004's bed system was observed to have two bed rails up and a mattress with raised edges. PSW #110 indicated that bed rails were in use for resident #004. On November 29, 2017, resident #004 was observed in his/her bed with two bed rails up. Upon becoming aware of the Inspector, the resident got up out of bed and met the Inspector at the bedroom doorway. Resident #004 was unable to respond to the Inspector's questions about his/her bed rail use. Resident #004 indicated to the Inspector that he/she had nothing to do with the bed rails and had no idea how they worked. PSW #106 indicated that resident #004 was very confused and that bed rails had been in use for resident #004 since his/her admission to the home. Resident #004 was admitted to the home on an identified day in 2017. The Inspector reviewed resident #004's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was not located. In the resident's care plan, within a section related to activities of daily living, there was an intervention, made on an identified day in 2017, which indicated that "Bed rail; Resident request bed rails for Positioning in bed/bed mobility, using 2 quarter rails".

Related to resident #005:

On November 28, 2017, resident #005's bed system was observed to have two bed rails up, and a flat mattress. RPN #107 indicated that bed rails had been in use for resident #005 since the resident's admission to the home. Resident #005 was admitted to the home on an identified day in 2017. On November 29, 2017, resident #005 was observed in his/her bed with the bed rails up. PSW #108 indicated that when she works on the unit, bed rails are always in use for resident #005. The Inspector reviewed resident #005's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was not located. The resident's care plan did not reference the use of bed rails.

On November 30, 2017, the Inspector met with the VP of Nursing to discuss resident #001 - #005. The VP of Nursing confirmed that with the exception of resident #001, there was no bed rail related assessment on record for the identified residents. The VP of Nursing printed the care plans for each resident, and any bed rail related progress notes, for the Inspector, and concluded that the assessment process that she had developed had not been followed for the five identified residents.

The scope of the non-compliance described above is widespread and presents a potential for actual harm/risk. As well, the non-compliance is ongoing, with a compliance order having been served to the licensee, pursuant to O. Reg. 79/10, s. 15 (1), on April 13, 2017, which was to have been complied with by August 4, 2017. A subsequent compliance order will be served on the licensee. [s. 15. (1) (a)]

Additional Required Actions:

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

Issued on this 16th day of January, 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 LAPENSEE (133)
Inspection No. / No de l'inspection :	2017_625133_0019
Log No. / No de registre :	009017-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jan 16, 2018
Licensee / Titulaire de permis :	ST. PATRICK'S HOME OF OTTAWA INC. 2865 Riverside Dr., OTTAWA, ON, K1V-8N5
LTC Home / Foyer de SLD :	ST PATRICK'S HOME 2865 RIVERSIDE DRIVE, OTTAWA, ON, K1V-8N5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Janet Morris

To ST. PATRICK'S HOME OF OTTAWA INC., 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)

Linked to Existing Order / Lien vers ordre existant: 2017_617148_0014, CO #001;

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 is ordered to:

1. Re-evaluate all bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). Related to zone 3, if faced with a borderline pass/fail decision at any point along the length of the rail being tested, consider mitigation as per the HC guidance document, such as the use of accessories to reduce the risk of entrapment. The zone specific test results are to be documented.

2. Ensure that any/all persons conducting the bed system re-evaluations are trained in accordance with the methods prescribed by the HC guidance document and can demonstrate a working knowledge of the seven zones of entrapment and the prescribed testing methods for zones 1-4, as per the HC guidance document.

3. Establish and implement a process for ensuring that any bed system failures are addressed immediately. Document corrective actions taken. Consider the guidance outlined in the FDA 2006 document "A Guide for Modifying Bed

Systems and Using Accessories to Reduce the Risk of Entrapment", a companion document to the HC guidance document. Should it be unavoidable that a resident must remain in a bed system that fails the prescribed entrapment zone testing, for any period of time, take immediate steps to prevent resident entrapment, taking into consideration all potential zones of entrapment. Steps taken are to be documented.

4. Maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident and which reflects the most recent evaluation for each bed system. Re-evaluate bed systems as required, such as when a new bed system is created as a result of a change or replacement of components, and when there is reason to believe some components are worn (eg. Rails wobble or are damaged, mattresses are softer)

5. Develop and implement a documented interdisciplinary team assessment process for all residents with one or more bed rails in use and for all residents for which the use of one or more bed rails are being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (FDA, 2003).

6. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternative to bed rail use, and that the interventions or changes are trialed if appropriate and dependent on the resident's assessment, during a specified observation period prior to the application of any bed rails or prior to the removal from use of any bed rails.

7. Ensure that the interdisciplinary team clearly documents the resident assessments/reassessments, including the risk-benefit analysis, as prescribed by the 2003 FDA clinical guidance document, and ensuing recommendation. As per the 2003 FDA clinical guidance document, if clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower that that of other interventions or of not using them, bed rails may be indicated for use. The use of bed rails is to be approved by the interdisciplinary team. The names of the team members who participate in the assessment and decision making process is to be documented.

8. Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team. Where bed rails are to be used, include all required information as specified in the FDA 2003 clinical guidance document, such as related to the use of bed rails for a medical symptom or condition vs. bed rails used for a resident's mobility and/or transferring. Specify how the bed rails are to be used, and when.

9. Develop and implement a documented ongoing auditing process to ensure that all requirements of this compliance order are satisfied.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that, where bed rails are used, 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.

On April 13, 2017, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of Critical Incident System Inspection #2017_617148_0014. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by August 4, 2017.

Part 1 of the compliance order was related to residents' bed systems and parts 2 to 4 of the compliance order were related to the assessment of residents.

In relation to residents' bed systems:

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test

tools (cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

On November 24, 2017, the Chief Executive Officer (CEO) provided the Inspector with the bed system information binder, which contained the results of all of the bed system evaluations that had been conducted in response to part 1 of the compliance order. The CEO indicated that there were three staff members (#113, #114, #115) trained to conduct bed system evaluations, two of which (#113, #115) had conducted all of the bed system evaluations in response to the compliance order. It was indicated that all bed systems that had been evaluated had passed.

As per the bed system information binder, maintenance worker #113 had conducted all of the bed system evaluations on six of the nine care units and some of the bed system evaluations on two of the remaining three care units. Maintenance worker #115 had conducted all of the bed system evaluations on one of the nine care units and some on two of the nine care units. The CEO indicated that housekeeping worker # 114 had conducted the subsequent bed system evaluations.

On November 24, 2017, the Inspector observed resident #006, #007 and #008's bed systems and noted that these and bed systems throughout the care unit were of the same type. As per the information contained in the bed system information binder, it was noted that resident #006, #007 and #008's bed systems were given a "pass". The Inspector observed that the bed rails on resident #006 - #008's bed systems were loose and that there was a gap of approximately 1 ½ inches to 1 ¾ inches between the inside surface of the rails and the edge of the mattress (without compression). This area is known as Zone 3, as per the HC guidance document, and presents a risk of entrapment of a resident's head. This gap lead the Inspector to request a demonstration of a bed system evaluation, as zone 3 would be vulnerable to failure depending on the compressibility of the mattress in place on the bed system, given the observed gap and degree of play with the rails. The zone 3 test requires that the cone (not attached to the cylinder) be placed horizontally in the gap between the bed rail and the mattress. The cone is to be allowed to sink into the space by its own weight. If the cone's center line is at or below the top surface of the mattress, the space fails the test.

On November 24, 2017, housekeeping worker #114 accompanied the Inspector

to resident #006's bedroom, with the testing tool as prescribed by the HC guidance document. The Inspector requested that the housekeeping worker conduct an evaluation of resident #006's bed system. The process demonstrated was not in accordance with the testing prescribed by the HC guidance document. Housekeeping worker #114 was unable to demonstrate testing for zones 1 – 4 as per the HC guidance document and did not demonstrate knowledge of zones 1 - 4. The Inspector and the housekeeping worker reviewed the prescribed testing procedure for zones 1-4, as per the HC guidance document. Housekeeping worker #114 indicated that, for example, for zone 2 and 3, he was taught to use the fully assembled tool (cone and cylinder) and to place it in a way that the cone was between the rail and the mattress, then to observe if the cone sank down below the mattress. If the cone portion sank down below the mattress, then he would consider it as a fail. Housekeeping worker #114 indicated that he was not aware that the zone 2 and 3 test required use of the cone only and that the zone 2 test also required use of a scale, and required the cone to be inserted, small end first, into the gap between the mattress and the lower edge of the rail, between rail supports. Then, the scale is to be attached to the loop on the cone and the cone is to be pulled with 12 pounds of pressure at any angle that increases the chance of the cone going through the space. Related to zone 3, housekeeping worker #114 indicated that he had not been aware that if the cone's center line was at the surface of the mattress, after the cone had been allowed to compress the mattress, then zone 3 would be considered a "fail". Related to zone 4, housekeeping worker indicated he had never been taught to observe the level on the cylinder or to observe the green "pass" or red "fail" section. Housekeeping worker #114 proceeded to test zones 1 - 4, on the right side of the bed system. Zone 1 was tested and passed, due to the size of the openings within the perimeter of the rail. Zone 2 was tested and passed, due to the design of the bed deck, which prevented the small end of the cone from passing through the space under the rail, between the rail supports. Zone 3 was tested, and the cone's center line was slightly above the edge of the compressed mattress, which may be considered a borderline pass as per the HC guidance document. Zone 4 was tested, and it passed, as the cylinder touched the rail in the green section when held level and in the prescribed position. Housekeeping worker #114 indicated that he had been trained to conduct bed system evaluations by the Vice President (VP) of Building Operations.

On November 28, 2017, the VP of Building Operations indicated that when the bed system testing tool was received, he also received a video from the tool

supplier. The VP of Building Operations indicated that he and maintenance worker #115 had watched the video in order to learn how to use the testing tool.

On November 28, 2017, maintenance worker #113 accompanied the Inspector to resident #007's bedroom, with the testing tool as prescribed by the HC guidance document. The Inspector requested that the maintenance worker conduct an evaluation of resident #007's bed system. The process demonstrated was not in accordance with the testing prescribed by the HC guidance document. The maintenance worker was unable to demonstrate testing for zones 1 – 4 as per the HC guidance document and did not demonstrate knowledge of zones 1 – 4. For example, the maintenance worker positioned the cone horizontally in between the mattress and the rail and noted that the cone did not go down below the surface of the mattress. The maintenance worker then placed the cone on the mattress, pointing towards an opening in the rail and noted that the cone did not sink down into the mattress. The maintenance worker indicated that he would indicate a pass for zones 1, 2 and 3 given the tests he had conducted. The maintenance worker indicated that he was not aware that if the centre line of the cone was at the surface of the mattress, zone 3 would be considered a fail. The Inspector then requested that the maintenance worker contact the VP of Building Operations and request that he join the Inspector and the maintenance worker. Upon the arrival of the VP of Building Operations, the maintenance worker conducted what he indicated would be the final test, for zone 4, which was to position the small end of the cone down in between the edge of the mattress and the rail. As the large end of the cone did not go down below the mattress surface, the maintenance worker indicated it was a pass. The process demonstrated was the initial step in performing a zone 2 test, which is to include the use of a scale to pull the cone down. The VP of Building Operations indicated that it was maintenance worker # 115 who had begun the home wide bed system evaluation process in response to the compliance order. The VP of Building Operations indicated that maintenance worker #115 had found that due to the design of the bed systems in the home, the bed deck always prevented the large end of the cone from going down under the rail and therefore they stopped using the scale to attempt to pull the cone down. The VP of Building Operations indicated that maintenance worker #115 had also found that zone 4 passed on all bed systems he had evaluated, with the assembled tool (cone and cylinder), with use of the level and observation of the "pass" and "fail" zones on the cylinder. The VP of Building Operations indicated that zone 4 always passed as a result of the design of the rails, and therefore they stopped testing zone 4. The VP of Building Operations

indicated that even with a softer mattress, zone 4 would always pass due to the design of the rails. Zones 1 – 4 were subsequently tested by maintenance worker #113 in the prescribed way and all zones passed.

On November 28, 2017, the Inspector met with maintenance worker #115. He indicated that he and the VP of Building Operations had watched a video in order to educate themselves about how to conduct a bed system evaluation. He indicated that he recalled having done the zone 2 test with the scale, and the zone 4 test with the fully assembled tool with observation of the level. The maintenance worker indicated that due to the design of the bed decks and bed rails, zone 2 and 4 would always pass. Related to zone 3, the maintenance worker indicated he was having trouble recalling, however, he believed that if he had observed that the cone's center line was at the surface of the mattress he would have questioned it. Maintenance worker #115 indicated that he had questioned the results of the zone 3 test for mattresses with raised edges. The Inspector requested that the maintenance worker accompany the Inspector to a bedroom where there was such a mattress in use, with the testing tool.

On November 28, 2017, maintenance worker #115 and the Inspector observed resident #009's bed system. The mattress in place had highly compressible raised edges, along the full length of the bed rails. Maintenance worker #115 placed the cone horizontally in the gap between the mattress and the right bed rail and the cone sank down in between the raised edge and the rail readily. The same occurred on the left side. Maintenance worker indicated that in discussion with the VP of Building Operations, they had not considered this as a fail as the cone did not sink down below the level of the mattress beyond the raised edge. The HC guidance document was reviewed and zone 3 was discussed. Zone 3 is the space between the inside surface of the rail and the mattress compressed by the weight of a resident's head. Zone 3 presents the risk of entrapment of a resident's head. With a mattress with raised edges, such as the mattress in use for resident #009, zone 3 is raised when compared to mattresses without raised edges. Maintenance worker #115 indicated that he would now consider this as a fail. The Inspector and the maintenance worker proceeded to observe resident #010's bed system, which also had a mattress with raised edges. The bed rails were not in use for resident #010 and were tied down. The maintenance worker untied the bed rails and proceeded to test zone 3. It was again observed that zone 3 with such a mattress failed the testing process readily.

The VP of Building Operations and the Support Services Manager (SSM) were subsequently informed that the mattresses with raised edges failed zone 3. The VP of Building Operations and the SSM indicated they were not aware how many such mattresses were in use with bed rails in the home. The VP of Building Operations indicated they would work towards a solution.

On November 30, 2017, the VP of Nursing indicated that it had been determined that there were 47 residents with raised edge mattresses with bed rails in use. The VP of Nursing indicated that there were 28 new mattresses on order and more had been ordered. The VP of Nursing indicated that the use of bed rails would be reconsidered for every resident and that bed rails would be tied down if they were not needed. The VP of Nursing indicated that if bed rails were needed, they would switch the raised edge mattresses with flat mattresses or implement the use of accessories such as gap fillers, to reduce the risk of entrapment related to zone 3. The VP of Nursing indicate that the first and second floor units were completed.

On December 1, 2017, the VP of Nursing indicated that for 13 of the 47 residents, the bed rails in use on the bed system which included a raised edge mattress had been tied down, or, accessories such as gap fillers had been put into use, to reduce the risk of entrapment. The VP of Nursing indicated that there were 34 residents remaining with raised edge mattresses and bed rails in use, with no interventions in place. The VP of Nursing indicated that these residents would be put on an enhanced monitoring program and that extra nursing staff would be brought in to allow for the enhanced monitoring.

On December 5, 2017, the VP of Nursing indicated that as a result of resident reassessments related to bed rail use, mattress switches and accessory use, there remained 11 residents with bed rails in use with a raised edge mattress that required enhanced monitoring. With three additional mattress changes planned for the day, the VP of Nursing indicated that there would be 8 residents remaining that required enhanced monitoring by the end of the day.

On December 5, 2017, the VP of Building Operations indicated that he had provided training related to bed system evaluation to maintenance worker #113, #115, housekeeping worker #114 (as previously referenced) and two additional staff members. The VP of Building Operations indicated that where raised edge mattresses were being switched out for flat mattresses, for residents with bed rails in use, the resulting new bed system was being evaluated.

In relation to resident assessment:

The previously referenced HC guidance document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States. The companion documents referred to in the HC Guidance Document are identified as useful resources and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making. 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 (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is specified that any decision to use or to discontinue use of bed rails should be made within the context of an individualized resident assessment using an interdisciplinary team. Numerous factors are to be considered and are specified. The process is to result in a documented risk benefit assessment, prior to the team's conclusion that bed rails may be indicated for use. Specific direction is provided in relation to three aspects of the required risk benefit assessment, and they are as follows:

a) Assessment of the relative risk of using bed rails compared with not using bed rails for each individual resident.

b) Identification of why other care interventions are not appropriate or not effective if previously attempted and determined not to be the treatment of choice for the resident.

c) Comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident.

The 2003 FDA Clinical Guidance document specifies that where clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination has been made that the risk of bed rail use is lower than that of other interventions or of not using them, bed rails may be indicated for use. The decision to use or to discontinue use of bed rails is to be made by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On November 28, 2017, the Inspector met with the VP of Nursing to discuss the resident assessment process that she had developed with regards to bed rail use. The VP of Nursing indicated that residents who are supposed to have one or two bed rails in use would have had an assessment completed, and for those who are not supposed to have bed rails in use, the bed rails on the resident's bed would have been tied down. Looking at the new assessment, titled "Bedrail and Entrapment Risk Assessment – V2", the Inspector noted that it did not contain all factors, elements and conditions as outlined in the 2003 FDA document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care settings". The home was specifically directed to develop an assessment process in accordance with the clinical guidance document in part 2 of the compliance order. Following discussion, the VP of Nursing indicated that she had not seen the clinical guidance document before this meeting. The VP of Nursing indicated that she had not referenced the compliance order while she was working on the assessment process. The VP of Nursing indicated that she had known that she had to develop an assessment for residents related to bed rail use and that she had looked at what other long term care homes were doing with regards to such assessments.

The clinical guidance document outlines, for example, that an individual resident assessment is to be conducted by an interdisciplinary team and is to include: medical diagnosis, conditions, symptoms and/or behavioural symptoms; sleep habits; medication; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling, etc. The assessment process is to result in risk benefit assessment, as previously referenced in this report. In discussion with the VP of Nursing, on November 29, 2017, it was concluded that the assessment process that she had developed was focused on the individual resident's mobility, exclusively.

In reference to the consideration of alternatives to bed rail use, as per part 3 of the compliance order, on November 29, 2017, the VP of Nursing confirmed that the assessment process that she had developed did not result in the consideration of alternatives to bed rail use.

In reference to the residents' written plan of care, as per part 4 of the compliance order, on November 29, 2017, the VP of Nursing indicated that it was expected that if a resident had bed rails in use, it was expected that there would be an assessment within the resident's health care record, with an associated progress

note, and details of the resident's use of bed rails within the resident's care plan.

Related to resident #001:

On November 28, 2017, resident #001 was observed in his/her bed with two bed rails up, and a mattress with raised edges. Personal Support Worker (PSW) #103 indicated that the bed rails were always up for resident #001. On November 29, 2017, PSW #S109 indicated that bed rails had been in use for resident #001 since his/her admission to the home. Resident #001 was admitted to the home on an identified day in 2017. The Inspector reviewed resident #001's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was located. The assessment, completed on the resident's admission day, indicated that bed rails were not required for resident #001. The resident's care plan did not include reference to the use of bed rails.

Related to resident #002:

On November 28, 2017, resident #002's bed system was observed to have two bed rails up, and a flat mattress. PSW #104 indicated that bed rails have been in use for resident #002 since his/her admission to the home and they are always up. Resident #002 was admitted to the home on an identified day in 2017. On November 29, 2017, PSW #111 indicated that bed rails are always up and in use for resident #002. The Inspector reviewed resident #002's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was not located. The resident's care plan did not include reference to the use of bed rails.

Related to resident #003:

On November 28, 2017, resident #003's bed system was observed to have two bed rails up, and a mattress with raised edges. RPN #112 indicated that bed rails were in use for resident #003. On November 29, 2017, PSW #105 indicated that bed rails have been in use for resident #003 since the resident's admission to the home. Resident #003 was admitted to the home on an identified day in 2017. The Inspector reviewed resident #003's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was not located. A progress note, made on the resident's admission day, indicated that bed rails were not required for resident #003. The resident's care plan did not include reference to the use of bed rails.

Related to resident #004:

On November 28, 2017, resident #004's bed system was observed to have two bed rails up and a mattress with raised edges. PSW #110 indicated that bed rails were in use for resident #004. On November 29, 2017, resident #004 was observed in his/her bed with two bed rails up. Upon becoming aware of the Inspector, the resident got up out of bed and met the Inspector at the bedroom doorway. Resident #004 was unable to respond to the Inspector's questions about his/her bed rail use. Resident #004 indicated to the Inspector that he/she had nothing to do with the bed rails and had no idea how they worked. PSW #106 indicated that resident #004 was very confused and that bed rails had been in use for resident #004 since his/her admission to the home. Resident #004 was admitted to the home on an identified day in 2017. The Inspector reviewed resident #004's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was not located. In the resident's care plan, within a section related to activities of daily living, there was an intervention, made on an identified day in 2017, which indicated that "Bed rail; Resident request bed rails for Positioning in bed/bed mobility, using 2 quarter rails".

Related to resident #005:

On November 28, 2017, resident #005's bed system was observed to have two bed rails up, and a flat mattress. RPN #107 indicated that bed rails had been in use for resident #005 since the resident's admission to the home. Resident #005 was admitted to the home on an identified day in 2017. On November 29, 2017, resident #005 was observed in his/her bed with the bed rails up. PSW #108 indicated that when she works on the unit, bed rails are always in use for resident #005. The Inspector reviewed resident #005's health care record. A "Bedrail and Entrapment Risk Assessment – V2" was not located. The resident's care plan did not reference the use of bed rails.

On November 30, 2017, the Inspector met with the VP of Nursing to discuss resident #001 - #005. The VP of Nursing confirmed that with the exception of resident #001, there was no bed rail related assessment on record for the identified residents. The VP of Nursing printed the care plans for each resident, and any bed rail related progress notes, for the Inspector, and concluded that the assessment process that she had developed had not been followed for the five identified residents.

The scope of the non-compliance described above is widespread and presents a potential for actual harm/risk. As well, the non-compliance is ongoing, with a compliance order having been served to the licensee, pursuant to O. Reg. 79/10, s. 15 (1), on April 13, 2017, which was to have been complied with by August 4, 2017. A subsequent compliance order will be served on the licensee. [s. 15. (1) (a)]
(133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 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 16th day of January, 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 LAPENSEE

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