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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700 rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

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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 9, 2018	2017_659189_0025	027086-17	Resident Quality Inspection

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
5015 Spectrum Way Suite 600 MISSISSAUGA ON 000 000

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

WESTSIDE
1145 Albion Road Rexdale ON M9V 4J7

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

NICOLE RANGER (189), BERNADETTE SUSNIK (120), CECILIA FULTON (618)

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): November 30, December 1, 4, 5, 6, 7, 8, 2017.

The following complaint were inspected concurrently with the RQI: # 022735-17, related to safe and secure home.
The following follow up were inspected concurrently with the RQI # 011806-17, 021615-17, 024956-17 related to pain management, plan of care, bed rails, lighting requirements, prevention of abuse and neglect, transferring and positioning.

During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care (DOC), Assistant Director of Care (ADOC), Environmental Service Manager (ESM), Registered Dietitian (RD), Staff Educator, RAI MDS Coordinator, Nurse Manager, Programs Manager, Acting Nutrition Manager, Family Council President, Residents' Council President, registered nurse (RN), registered practical nurse (RPN), personal support workers (PSW), residents, family members.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Residents' Council
Safe and Secure Home
Skin and Wound Care

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 18.	CO #004	2016_344586_0007	120
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2017_646618_0015	618
O.Reg 79/10 s. 36.	CO #003	2017_646618_0015	618
O.Reg 79/10 s. 52. (2)	CO #001	2017_656596_0013	618
LTCHA, 2007 S.O. 2007, c.8 s. 6. (1)	CO #002	2017_646618_0015	618

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 were used, residents were assessed in accordance with prevailing practices to minimize risk to the resident.

An inspection (2016-344586-0007) was previously conducted April 1 to May 3, 2016, and non-compliance identified with respect to the licensee's bed safety program. A Compliance Order (CO) with multiple conditions was issued on June 1, 2016, for a due date of September 15, 2016. The CO included requirements to develop a tool or questionnaire to assess residents who used one or more bed rails for bed related safety risks identified in the Clinical Guidance document noted below, that an interdisciplinary team assess all residents who used bed rails, that their written plan of care be updated after being assessed, that health care staff be provided with and follow directions with respect to each resident's bed rail use requirements and two separate conditions to improve the bed entrapment evaluation process. During this follow-up visit, it was determined that the above noted requirements were not all met with respect to the resident clinical assessments.

A companion guide titled "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) provides the necessary guidance in establishing a clinical assessment where bed rails are used. It is cited in a guidance document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008" and was identified by the Ministry of Health and Long Term Care in 2012, as the prevailing practice.

Five residents (#020, 021, 022, 023, 024) were randomly selected during this inspection to determine if they were assessed for bed related safety risks in accordance with the clinical guidelines. The RAI-MDS Coordinator, who identified themselves as a registered practical nurse (RPN), confirmed that they had completed many of the assessments, including the five that were reviewed. The tool or questionnaire that was used by the RPN was titled “"Bed Rail Risk Assessment (BRRA)” to assess residents either upon admission, change in condition, change in bed system or annually.

A) The licensee's policy and procedure titled “Resident Safety (CARE 10-010.04) dated August 31, 2016, included direction that residents would be assessed by the interdisciplinary care team to determine the continued need for the bed rail on a quarterly basis (where bed rails were previously evaluated and the resident was previously assessed). Annually, all residents who used bed rails were required to receive a sleep observation and the DOC or delegate (RN or RPN) would complete the “Bed Rail Risk Assessment (BRRA)” form. In addition, residents who had a change in condition or where there was a change in their bed system (new or different mattress, re-attachment of a bed rail), the bed was to be re-evaluated by using the “Bed Rail Safety Assessment” and the resident re-assessed.

No guidelines or details were included in the policy about the sleep observation study, who would be involved in observing the resident, the specific observations that were necessary and how the information would be documented. According to the RPN and an ADOC, the personal support worker was to answer six questions related to how a resident behaved in bed over the course of the three nights and the answers documented on a computer program known as POC. If concerns were observed, the resident was considered to be at high risk or significant risk for a negative outcome related to bed rail use. The RPN or RN was then responsible for reviewing the outcomes and including the results on the BRRA form. The policy did not include what the strategies and options would be necessary if certain bed safety risks were identified and did not include what alternatives were available as a replacement to bed rails. None of the six questions included observing for body parts through the rail (zone 1), bruising or injury against the bed rail, if they fell out of bed and whether the resident used their bed rail safely and appropriately.

B) The BRRA form that was required to be developed using the Clinical Guidance document as a guide was confirmed to have been completed and implemented and included five sections. These sections included the reason for considering bed rails, type of mattress, risk factors related to the resident's status such as medical symptoms,

history of falls out of bed, ability to self-ambulate, medication use, cognition level, pain, etc., sleep observation study results (for three nights), bed mobility status, transfer abilities, a section to document what alternatives were trialled, type of bed rail being recommended and frequency for use. In addition, several guiding statements were included to direct the assessor in determining if the resident was not a candidate for bed rail use based on the answers to the questions.

Section 1 of the BRRA form included questions related to what alternatives were trialled, whether successful or not and how long they were trialled for. For residents #020 to #024, the answers provided included "none" or "N/A".

According to the ADOC and RPN, the five residents selected used bed rails in the past, before any of them were formally assessed and alternatives were therefore not trialled or not applicable. Each of the five residents were identified as non-candidates for bed rail use, and when the families were approached about the removal of the bed rails, they fought the decision and insisted they remain on the beds. The reason for the majority of the refusals was related to the fear of residents falling out of bed. Although the residents with risk factors of falling out of bed were provided with interventions such as falls mats and bed alarms, the families were not able to understand that bed rails were not a falls prevention device. The bed rails therefore remained on the beds and no further action was taken. The licensee followed the direction given by the SDM (Substitute Decision Maker) without balancing the licensee's responsibility to provide care according to an individual assessment, professional standards of care, and any applicable regulations. The requirement with regards to medical devices such as bed rails, is to try alternatives where appropriate, that can provide the resident with similar benefits with fewer risks despite the disapproval of the SDM. The final outcome would be presented to the SDM at the conclusion of the assessment and consent requested where necessary.

Sections 2, 3 and 4 of the BRRA form each included guidance statements (depending on the answers to the questions) that directed the assessor to inform the resident or SDM that bed rails were a significant risk for the resident and they would not qualify to use them. Further, the direction was to obtain consent from the resident/SDM (for continued use of bed rails) and to update the resident's plan of care. According to the licensee's policy, the plan of care would include strategies to reduce the risk of bed rail use that could lead to unsafe entrapment issues. For residents #020 to #024, no information was included in the written plan of care about any of the identified risks documented on their BRRA forms or any strategies to reduce them. The direction on the BRRA form did not include the need to determine what if anything could be implemented or done prior to

resorting to the use of one or bed rails or that the assessor needed to link back to section 1 (alternatives). If the assessor determined that the alternative was not successful or inappropriate, the assessor would then decide if bed rails were more of a benefit than a risk, thereby obtaining the appropriate consents. If the bed rails were more of a risk then a benefit, and bed rails remained in place at the insistence of the SDM without specific strategies, the licensee therefore did not follow all of the requirements to ensure that the resident was kept safe.

C) Residents #020-024 all received a bed safety assessment (BRRA) in October or November 2017. According to the documentation, all five residents received a sleep assessment in an identified time period in October 2016, and none in 2017. The RPN confirmed that they had used the results from the sleep observation study conducted by personal support workers in 2016, to complete the 2017 annual assessments for both bed rail safety and use. A new sleep observation study was not completed as specified in the licensee's policy. Over the course of one year, many changes to a resident's condition and ability to safely use a bed rail can change.

According to the 2017 BRRA forms for all five residents, none were qualified to have bed rails applied due to one or more identified risk factors such as inability to exit or enter their bed independently, medication use increasing the risk of falling or inability to self-ambulate. No documentation was made as to whether alternatives were trialled for each of the five residents as previously stated. According to the ADOC and RPN, the residents all had bed rails applied for a number of years before the formal introduction of the BRRA and that some of the SDMs or residents did not agree to remove the bed rails or try any alternatives.

Residents #021, 023 and 024, were all observed in bed on an identified date in December 2017, with either both of their rotating assist rails in the guard position or with one bed rail in the guard position (horizontal) and one in the transfer or assist position (vertical) and their left in the transfer position. Each resident's plan of care, was the same, that "both quarter length bed rails were to be applied on both sides for a sense of security and to facilitate bed mobility". The bed rail type was incorrectly identified for each resident and did not include any information about the positions the bed rails should have been in when the resident was in bed (or out of bed). Rotating assist bed rails present different risks, depending on the position they are placed in, whether in guard (suspension, climbing over the bed rail and entrapment) or whether in the transfer or assist position (entrapment).

1. Resident #020 was observed in bed on an identified date in December 2017, with two quarter rails elevated, a pillow on each side of their upper body and a falls risk mat on the floor on one side. The resident's written plan of care included the need to have both quarter length bed rails applied on both sides for a sense of security and to facilitate bed mobility. However, this was determined to be inaccurate as the resident was not able to use their bed rails as they were repositioned by two staff members and the resident could not provide any preferences about their bed rails. The resident's plan included a statement that the resident could not assist in any way during the transfer process and required a mechanical lift. The resident had dementia and was at a high risk of falls. The resident's personal service worker (PSW) identified that the resident went to hospital on an identified date, and that upon their return, they did not move while in bed, therefore the resident required staff to reposition them. The PSW included that the resident did not use their bed rails and it was their SDM/POA who insisted that they remain in use on the bed based on their past history of agitation. A re-assessment was not completed.

During their sleep observation in 2016, the resident was identified to require assistance to get out of bed, tried to get out of bed without calling for assistance, was a restless sleeper, slept close to the edge of the bed and had involuntary body movement. The resident's past,related to bed system related risks, were very different and could not be used to complete their 2017 BRRA form.

The most current BRRA form included information that the resident needed both bed rails for a sense of security and for turning in bed. Under the concerns section on the BRRA form, where the RPN was required to document what was discovered during the sleep observation study, only one risk factor was selected, that the resident needed assistance getting in and out of bed. Under another section, the resident was identified as being at risk of falling out of bed due to medications and would not qualify for bed rail use.

2. Resident #021 was identified during their sleep observation in 2016, to require assistance to get out of bed and had slept close to the edge of the bed or near the bed rail.

The most current BRRA form included information that the resident needed both bed rails for a sense of security and for turning in bed. Under the concerns section on the BRRA form, where the RPN was required to document what was discovered during the sleep observation study, only one risk factor was selected, that the resident needed assistance getting in and out of bed. Under another section, the resident was identified as being at risk of falling out of bed due to medications and would not qualify for bed rail use.

3. Resident #022 was not observed in bed on an identified date in December 2017, however it was noted that their bed system included two quarter bed rails elevated and an overly short therapeutic air surface that was very soft. The resident's clinical record identified that the surface was installed on an identified date. When the Environmental Services Supervisor was asked to provide the most current bed evaluation records, the resident's bed frame was documented as having a foam based mattress. The bed system had passed entrapment zones when measured in 2016, with the foam mattress in place. However, with the therapeutic air surface, it would not have been applicable to test the bed due to the soft, flexible nature of the surface (according to Health Canada). It therefore, would have automatically been required that the resident be re-assessed for safety risks. The resident's clinical records did not include a re-assessment and the resident did not have any accessories in place to mitigate the potential risks associated with entrapment zones in and around the bed rail.

The resident's written plan of care included that both quarter length bed rails were to be applied on both sides for sense of security and to facilitate bed mobility. The resident required extensive assistance with bed mobility provided by two staff members, needed a therapeutic mattress for skin integrity issues, needed to be turned and repositioned by staff and required weight bearing assistance by two staff for transfers.

The most current BRRA form included information that the resident needed bed rails to turn in bed and to have access to their bed controls. The sleep observations revealed a single risk factor related to the need for assistance to get out of bed. The RPN selected the same information on the BRRA form. Further, the RPN selected that the resident was not able to get out of bed without assistance and that the resident did not qualify for bed rail use.

4. Resident #023 was identified during their sleep observation in 2016, to have had agitation or restlessness while in bed and needed help getting out of bed.

The plan of care further included that the resident was not able to physically help to move in bed, required total assistance with bed mobility with one or two staff and required a mechanical lift and total assistance for transfers out of bed. The resident was therefore unable to use the bed rails independently.

The most current BRRA form included information that the resident needed both bed rails for a sense of security, for turning in bed and for getting in and out of bed. The

assessment did not appear to be in line with the plan of care. Under the concerns section on the BRRA form, where the RPN was required to document what was discovered during the sleep observation study, only one risk factor was selected, that the resident needed assistance getting in and out of bed. The agitation and restlessness concerns were not re-assessed and it was unclear whether that particular risk factor was still an issue. Under another section, the resident was identified as being at risk of falling out of bed due to medications, could not get out of bed without assistance and was not able to ambulate without assistance and would not qualify for bed rail use. The bed rails were left in place with the insistence of the SDM/POA.

5. Resident #024 was identified during their sleep observation in 2016, to have had agitation or was restless while in bed, slept on edge of bed, needed help to get out of bed, tried to get out of bed without using the call bell for assistance and had uncontrolled body movements at least once during the observation period.

The plan of care included that they were at high risk of falls, had dementia, required extensive assistance by two staff for bed mobility (therefore the resident could not use the bed rails independently) and included that the "Power of Attorney wanted rails up at all times".

The BRRA form included information that the resident needed bed rails for a sense of security, to turn in bed and to help get in and out of bed. The assessment did not appear to be in line with the plan of care. Under the concerns section of the BRRA form, where the RPN was required to document what was discovered during the sleep observation, only one risk factor was selected, that the resident needed assistance getting in and out of bed. . The agitation and restlessness, body movements, sleeping on the edge of the bed concerns were not re-assessed and it was unclear whether these particular risk factors were still an issue. Further, the RPN selected that the resident was at risk of falling out of bed, and could not get out of bed independently and that the resident did not qualify for bed rail use.

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

This Compliance Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. In respect to severity, there is potential for actual harm (2), for scope, the number of residents who have not been adequately assessed is widespread (3) and

previous non-compliance (4) related to bed safety was issued as a Compliance Order under the same section on June 1, 2016. [s. 15. (1) (a)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

During stage 1 of the RQI, the inspector observed an altered skin impairment for resident #005. Resident #005 was prescribed several treatments for a variety of skin conditions. The treatments were identified in the electronic Treatment Administration Record (TAR).

Interview with resident #005 revealed that he/she had been refusing one of the treatments prescribed for an area of skin impairment. Resident #005 stated that he/she did not like the treatments and that they had been refusing to have staff administer the treatment for about a month.

Review of the TAR for an identified month revealed that the identified treatment had been signed off as having been done on three identified dates, and signed off as having been refused on one identified date.

On an identified date and time, the Inspector and Nurse Manager (NM) # 104 went together to interview resident #005. Interview with resident #005 revealed that he/she had not received the treatment on the identified dates as they had refused the treatment. Resident #005 revealed that staff did come to offer the treatment, and that he/she

refused and it was not performed.

Interview with Registered staff #102, who had signed as having provided the treatment on one identified date, stated that he/she had performed the treatment as prescribed in the TAR.

Interview with registered staff #103, who had signed as having provided the treatment on one identified date, stated that he/she had not provided the treatment and could not recall this treatment prescription was on the TAR.

NM #105 reviewed the TAR with the Inspector and confirmed that on the two identified dates the treatment was signed off as having been given. NM confirmed that if a resident refuses a treatment, the refusal should be coded as refused in the TAR. NM confirmed that there was no documentation regarding the resident's ongoing refusal of the treatment.

Interview with the Director of Care revealed that he/she had spoken with registered staff #102 and in that conversation registered staff #102 confirmed that he/she had not administered the treatment which they had signed off in the TAR as being administered. [s. 6. (7)]

2. During stage 1 of the RQI, the inspector observed an area of altered skin integrity of resident #006's identified area. Interview with RPN #105 revealed that the resident sustained an unknown injury to an identified area on an identified date. RPN #105 reported that a skin assessment, pain assessment and a head injury routine (neurological flow sheet) was completed.

Review of the home's procedure "Fall Prevention and Injury Reduction", CARE5-O10.02, reviewed July 31, 2016, indicated that if a fall is unwitnessed or the resident has hit their head, a neurological assessment is initiated, and the resident is monitored for 72 hours.

Record review of the neurological flow sheet initiated on an identified date, revealed that on four shifts the neurological flow sheet was not completed by the registered staff. Interview and review with RPN #105 and the DOC confirmed that the neurological flow sheets were not completed as required, and the DOC confirmed that the care set out in the plan of care was not provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the care set out in the plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place was complied with.

During stage 1 of the RQI, the inspector observed an altered skin impairment for resident #005. Resident #005 was prescribed several treatments for a variety of skin conditions. The treatments were identified in the electronic Treatment Administration Record (TAR).

Interview with resident #005 revealed that he/she had been refusing one of the treatments prescribed for an area of skin impairment. Resident #005 stated that he/she did not like the treatments and that they had been refusing to have staff administer the treatment for about a month.

Review of the TAR for an identified month revealed that the identified treatment had been

signed off as having been done on three identified dates, and signed off as having been refused on one identified date. Review of the TAR for another identified month revealed the treatment was signed off as given 20 out of 30 days and signed off as refused six times and signed off as other four times.

On an identified date and time, the Inspector and Nurse Manager (NM) # 104 went together to interview resident #005. Interview with resident #005 revealed that he/she had not received the treatment on the two identified date as they had refused the treatment. Resident #005 revealed that staff did come to offer the treatment, and that he/she refused and it was not performed.

Interview with Registered staff #102, who had signed as having provided the treatment on one identified date, stated that he/she had performed the treatment as prescribed in the TAR.

Interview with registered staff #103, who had signed as having provided the treatment on one identified date, stated that he/she had not provided the treatment and could not recall this treatment prescription was on the TAR.

NM #105 reviewed the TAR with the Inspector and confirmed that on the two identified dates the treatment was signed off as having been given. NM confirmed that if a resident refuses a treatment, the refusal should be coded as refused in the TAR. NM confirmed that there was no documentation regarding the resident's ongoing refusal of the treatment.

Interview with the Director of Care (DOC) revealed that he/she had spoken with registered staff #102 and in that conversation registered staff #102 confirmed that he/she had not administered the treatment which they had signed off in the TAR as being administered.

Review of the homes' policy, titled LTC- Medication Administration, effective date August 31, 2016, states "All medication administered, refused or omitted will be documented immediately after administration on the MAR/TAR or eMar/eTAR using the proper code by the administering Nurse.

Interview with the DOC revealed that this policy and this expectation would apply in the case of resident #005's treatment and that the staff members who had not signed the TAR with the proper coding had not followed the policy. [s. 8. (1) (a),s. 8. (1) (b)]

2. A review of the home's procedure "Registered Staff Cleaning Schedule", indicated that as part of the weekly cleaning schedule, staff are to clean the resident's aero chambers and nebulizers and store them in individual bags.

During an observation of the medication administration pass with RPN #105 on an identified date, the inspector observed 11 residents' aero chambers to be stored in the medication cart, touching each other and not in individual residents' bag, increasing the risk of potential cross contamination. Interview with the RPN #105 reported that the aero chambers should be stored in individual bags.

Interview with the DOC confirmed that the aero chambers should be cleaned, stored in individual bags, and labelled with the residents' name, to decrease the risk of cross contamination as per home's procedure. [s. 8. (1)]

3. A review of the home policy "Drug Inventory Control – Disposal of Discontinued/Expired medications", revised January 2017, directed staff for discontinued or out dated medication, it is to be stored in a storage area in the nursing station and that it is separate from drugs that are available for administration to a resident.

During an observation of the medication administration pass with RPN #105 in December 2017, the inspector observed an expired medication for resident #006. The medication was expired at the end of November 2017. The inspector also observed a discontinued medication for resident #025. The medication was discontinued in September 2017. Interview with RPN #105 revealed that the expired medication and discontinued medication should not be stored in the medication cart with the current available drugs for the residents.

Interview with the DOC confirmed that for discontinued or out dated medication, they are to be stored in a storage area in the nursing medication room, and that it is separate from drugs that are available for administration to a resident [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures are developed and implemented in accordance with manufacturer's specifications, using at a minimum a low level disinfectant in accordance with evidence-based practices and, if there are none, with prevailing practices, for cleaning and disinfection of:

i. resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
ii. supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

Observation of resident #004's wheelchair, made on an identified date, found the chair to be unclean with a large stain on the seat cushion. Subsequent observation made on another identified date, found the chair to be in the same, unclean condition.

The ADOC confirmed that resident #004's seat cushion was in an unclean condition and that staff should not have allowed this chair to be in this condition, and they should have cleaned it. [s. 87. (2) (b)]

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

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

s. 135. (3) Every licensee shall ensure that,
(a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions; O. Reg. 79/10, s. 135 (3).
(b) any changes and improvements identified in the review are implemented; and O. Reg. 79/10, s. 135 (3).
(c) a written record is kept of everything provided for in clauses (a) and (b). O. Reg. 79/10, s. 135 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that :(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed, (b) corrective action is taken as necessary, and (c) a written record is kept of everything required under clauses (a) and (b).

During the record review of the home's Medication Incident Summary for an identified time period, the inspector selected three medication incidents to review. The medication incident for resident #009 which was identified on an identified date, revealed that medication pouches found on an identified date in the medication cart was not given but signed in EMAR as administered. The medication incident form revealed that corrective action had not been taken.

Interview with the DON confirmed that in regards to resident #009 medication incident, corrective action to prevent reoccurrence was not documented. [s. 135. (2)]

2. The licensee has failed to ensure that: (a) a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, (b) any changes and improvements identified in the review are implemented, and (c) a written record is kept of everything provided for in clause (a) and (b).

During the record review of the home's Medication Incident Summary for an identified time period, the inspector selected two medication incidents to review. The medication incident for resident #009 which was identified on an identified date and medication incident for resident #010 was identified on an identified date. A review of the Professional Advisory Committee (PAC) meeting minutes for an identified month, did not reveal that a quarterly review was undertaken of all medication incidents and adverse drug reactions that had occurred in the home since the time of the last review, that any changes and improvements identified in the review are implemented.

Interview with the DON confirmed that at PAC meeting held and a review of the medication incidents in the home for the identified time period were not reviewed or analyzed by the team. [s. 135. (3)]

Issued on this 15th 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) :	NICOLE RANGER (189), BERNADETTE SUSNIK (120), CECILIA FULTON (618)
Inspection No. / No de l'inspection :	2017_659189_0025
Log No. / No de registre :	027086-17
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 9, 2018
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 5015 Spectrum Way, Suite 600, MISSISSAUGA, ON, 000-000
LTC Home / Foyer de SLD :	WESTSIDE 1145 Albion Road, Rexdale, ON, M9V-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lydia Baksh

To REVERA LONG TERM CARE 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: 2016_344586_0007, 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 shall complete the following:

1. All residents who have been assessed as being able to use bed rails and have bed rails applied while in bed, shall be re-assessed in 2018, using sleep observation data collected by staff just prior to completing the Bed Rail Risk Assessment form. Residents #020 to #024 shall be immediately re-assessed using current sleep observation study data.

2. The Bed Rail Risk Assessment form shall be amended to include details as to why alternatives were not trialled if terms such as "N/A" or "None" are used.

3. The sleep observation study questions shall include whether any body parts were observed through the rail (zone 1), whether the resident sustained any bruising or injury against the bed rail, whether they fell out of bed and whether the resident used their bed rail safely and appropriately.

4. All residents with rotating assist bed rails shall have their written plan of care amended to include which type of bed rail is to be employed and in what specific position (either guard or transfer) on each side of the bed.

5. Amend the policy titled “Resident Safety", CARE 10.010.04 dated August 31, 2016 (related to clinical assessments of residents), to include additional and relevant information noted in the prevailing practices identified as the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", U.S. F.D.A, April 2003) and "A Guide to Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment", U.S. F.D.A., June 21, 2006). At a minimum the policy shall include;

a) alternatives that are available for the replacement of bed rails and the process of trialling the alternatives and documenting their use; and
b) what interventions are available to mitigate any identified bed safety entrapment, suspension or injury risks; and
c) the role of the SDM and/or resident in selecting the appropriate device for the resident’s unique identified care needs; and
d) the role of and responsibilities of personal support workers with respect to observing residents in bed related to their bed systems (which includes bed rails, bed frame, accessories, mattresses, bed remote control) and associated safety hazards.

All care staff shall be informed of the changes made to the above amended policy

Grounds / Motifs :

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

An inspection (2016-344586-0007) was previously conducted April 1 to May 3, 2016, and non-compliance identified with respect to the licensee’s bed safety program. A Compliance Order (CO) with multiple conditions was issued on June 1, 2016, for a due date of September 15, 2016. The CO included requirements to develop a tool or questionnaire to assess residents who used one or more bed rails for bed related safety risks identified in the Clinical Guidance document noted below, that an interdisciplinary team assess all residents who used bed rails, that their written plan of care be updated after being assessed, that health care staff be provided with and follow directions with respect to each resident’s bed rail use requirements and two separate conditions to improve the bed

entrapment evaluation process. During this follow-up visit, it was determined that the above noted requirements were not all met with respect to the resident clinical assessments.

A companion guide titled "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) provides the necessary guidance in establishing a clinical assessment where bed rails are used. It is cited in a guidance document developed by Health Canada titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latch Reliability and Other Hazards, March 2008" and was identified by the Ministry of Health and Long Term Care in 2012, as the prevailing practice.

Five residents (#020, 021, 022, 023, 024) were randomly selected during this inspection to determine if they were assessed for bed related safety risks in accordance with the clinical guidelines. The RAI-MDS Coordinator, who identified themselves as a registered practical nurse (RPN), confirmed that they had completed many of the assessments, including the five that were reviewed. The tool or questionnaire that was used by the RPN was titled ""Bed Rail Risk Assessment (BRRA)" to assess residents either upon admission, change in condition, change in bed system or annually.

A) The licensee's policy and procedure titled "Resident Safety (CARE 10-010.04) dated August 31, 2016, included direction that residents would be assessed by the interdisciplinary care team to determine the continued need for the bed rail on a quarterly basis (where bed rails were previously evaluated and the resident was previously assessed). Annually, all residents who used bed rails were required to receive a sleep observation and the DOC or delegate (RN or RPN) would complete the "Bed Rail Risk Assessment (BRRA)" form. In addition, residents who had a change in condition or where there was a change in their bed system (new or different mattress, re-attachment of a bed rail), the bed was to be re-evaluated by using the "Bed Rail Safety Assessment" and the resident re-assessed.

No guidelines or details were included in the policy about the sleep observation study, who would be involved in observing the resident, the specific observations that were necessary and how the information would be documented. According to the RPN and an ADOC, the personal support worker was to answer six questions related to how a resident behaved in bed over the course of the three

nights and the answers documented on a computer program known as POC. If concerns were observed, the resident was considered to be at high risk or significant risk for a negative outcome related to bed rail use. The RPN or RN was then responsible for reviewing the outcomes and including the results on the BRRA form. The policy did not include what the strategies and options would be necessary if certain bed safety risks were identified and did not include what alternatives were available as a replacement to bed rails. None of the six questions included observing for body parts through the rail (zone 1), bruising or injury against the bed rail, if they fell out of bed and whether the resident used their bed rail safely and appropriately.

B) The BRRA form that was required to be developed using the Clinical Guidance document as a guide was confirmed to have been completed and implemented and included five sections. These sections included the reason for considering bed rails, type of mattress, risk factors related to the resident's status such as medical symptoms, history of falls out of bed, ability to self-ambulate, medication use, cognition level, pain, etc., sleep observation study results (for three nights), bed mobility status, transfer abilities, a section to document what alternatives were trialled, type of bed rail being recommended and frequency for use. In addition, several guiding statements were included to direct the assessor in determining if the resident was not a candidate for bed rail use based on the answers to the questions.

Section 1 of the BRRA form included questions related to what alternatives were trialled, whether successful or not and how long they were trialled for. For residents #020 to #024, the answers provided included "none" or "N/A".

According to the ADOC and RPN, the five residents selected used bed rails in the past, before any of them were formally assessed and alternatives were therefore not trialled or not applicable. Each of the five residents were identified as non-candidates for bed rail use, and when the families were approached about the removal of the bed rails, they fought the decision and insisted they remain on the beds. The reason for the majority of the refusals was related to the fear of residents falling out of bed. Although the residents with risk factors of falling out of bed were provided with interventions such as falls mats and bed alarms, the families were not able to understand that bed rails were not a falls prevention device. The bed rails therefore remained on the beds and no further action was taken. The licensee followed the direction given by the SDM (Substitute Decision Maker) without balancing the licensee's responsibility to

provide care according to an individual assessment, professional standards of care, and any applicable regulations. The requirement with regards to medical devices such as bed rails, is to try alternatives where appropriate, that can provide the resident with similar benefits with fewer risks despite the disapproval of the SDM. The final outcome would be presented to the SDM at the conclusion of the assessment and consent requested where necessary.

Sections 2, 3 and 4 of the BRRA form each included guidance statements (depending on the answers to the questions) that directed the assessor to inform the resident or SDM that bed rails were a significant risk for the resident and they would not qualify to use them. Further, the direction was to obtain consent from the resident/SDM (for continued use of bed rails) and to update the resident 's plan of care. According to the licensee's policy, the plan of care would include strategies to reduce the risk of bed rail use that could lead to unsafe entrapment issues. For residents #020 to #024, no information was included in the written plan of care about any of the identified risks documented on their BRRA forms or any strategies to reduce them. The direction on the BRRA form did not include the need to determine what if anything could be implemented or done prior to resorting to the use of one or bed rails or that the assessor needed to link back to section 1 (alternatives). If the assessor determined that the alternative was not successful or inappropriate, the assessor would then decide if bed rails were more of a benefit than a risk, thereby obtaining the appropriate consents. If the bed rails were more of a risk then a benefit, and bed rails remained in place at the insistence of the SDM without specific strategies, the licensee therefore did not follow all of the requirements to ensure that the resident was kept safe.

C) Residents #020-024 all received a bed safety assessment (BRRA) in October or November 2017. According to the documentation, all five residents received a sleep assessment in an identified time period in October 2016, and none in 2017. The RPN confirmed that they had used the results from the sleep observation study conducted by personal support workers in 2016, to complete the 2017 annual assessments for both bed rail safety and use. A new sleep observation study was not completed as specified in the licensee's policy. Over the course of one year, many changes to a resident's condition and ability to safely use a bed rail can change.

According to the 2017 BRRA forms for all five residents, none were qualified to have bed rails applied due to one or more identified risk factors such as inability to exit or enter their bed independently, medication use increasing the risk of

falling or inability to self-ambulate. No documentation was made as to whether alternatives were trialled for each of the five residents as previously stated. According to the ADOC and RPN, the residents all had bed rails applied for a number of years before the formal introduction of the BRRA and that some of the SDMs or residents did not agree to remove the bed rails or try any alternatives.

Residents #021, 023 and 024, were all observed in bed on an identified date in December 2017, with either both of their rotating assist rails in the guard position or with one bed rail in the guard position (horizontal) and one in the transfer or assist position (vertical) and their left in the transfer position. Each resident's plan of care, was the same, that "both quarter length bed rails were to be applied on both sides for a sense of security and to facilitate bed mobility". The bed rail type was incorrectly identified for each resident and did not include any information about the positions the bed rails should have been in when the resident was in bed (or out of bed). Rotating assist bed rails present different risks, depending on the position they are placed in, whether in guard (suspension, climbing over the bed rail and entrapment) or whether in the transfer or assist position (entrapment).

1. Resident #020 was observed in bed on an identified date in December 2017, with two quarter rails elevated, a pillow on each side of their upper body and a falls risk mat on the floor on one side. The resident's written plan of care included the need to have both quarter length bed rails applied on both sides for a sense of security and to facilitate bed mobility. However, this was determined to be inaccurate as the resident was not able to use their bed rails as they were repositioned by two staff members and the resident could not provide any preferences about their bed rails. The resident's plan included a statement that the resident could not assist in any way during the transfer process and required a mechanical lift. The resident had dementia and was at a high risk of falls. The resident's personal service worker (PSW) identified that the resident went to hospital on an identified date, and that upon their return, they did not move while in bed, therefore the resident required staff to reposition them. The PSW included that the resident did not use their bed rails and it was their SDM/POA who insisted that they remain in use on the bed based on their past history of agitation. A re-assessment was not completed.

During their sleep observation in 2016, the resident was identified to require assistance to get out of bed, tried to get out of bed without calling for assistance,

was a restless sleeper, slept close to the edge of the bed and had involuntary body movement. The resident's past,related to bed system related risks, were very different and could not be used to complete their 2017 BRRA form.

The most current BRRA form included information that the resident needed both bed rails for a sense of security and for turning in bed. Under the concerns section on the BRRA form, where the RPN was required to document what was discovered during the sleep observation study, only one risk factor was selected, that the resident needed assistance getting in and out of bed. Under another section, the resident was identified as being at risk of falling out of bed due to medications and would not qualify for bed rail use.

2. Resident #021 was identified during their sleep observation in 2016, to require assistance to get out of bed and had slept close to the edge of the bed or near the bed rail.

The most current BRRA form included information that the resident needed both bed rails for a sense of security and for turning in bed. Under the concerns section on the BRRA form, where the RPN was required to document what was discovered during the sleep observation study, only one risk factor was selected, that the resident needed assistance getting in and out of bed. Under another section, the resident was identified as being at risk of falling out of bed due to medications and would not qualify for bed rail use.

3. Resident #022 was not observed in bed on an identified date in December 2017, however it was noted that their bed system included two quarter bed rails elevated and an overly short therapeutic air surface that was very soft. The resident's clinical record identified that the surface was installed on an identified date. When the Environmental Services Supervisor was asked to provide the most current bed evaluation records, the resident's bed frame was documented as having a foam based mattress. The bed system had passed entrapment zones when measured in 2016, with the foam mattress in place. However, with the therapeutic air surface, it would not have been applicable to test the bed due to the soft, flexible nature of the surface (according to Health Canada). It therefore, would have automatically been required that the resident be re-assessed for safety risks. The resident's clinical records did not include a re-assessment and the resident did not have any accessories in place to mitigate the potential risks associated with entrapment zones in and around the bed rail.

The resident's written plan of care included that both quarter length bed rails were to be applied on both sides for sense of security and to facilitate bed mobility. The resident required extensive assistance with bed mobility provided by two staff members, needed a therapeutic mattress for skin integrity issues, needed to be turned and repositioned by staff and required weight bearing assistance by two staff for transfers.

The most current BRRA form included information that the resident needed bed rails to turn in bed and to have access to their bed controls. The sleep observations revealed a single risk factor related to the need for assistance to get out of bed. The RPN selected the same information on the BRRA form. Further, the RPN selected that the resident was not able to get out of bed without assistance and that the resident did not qualify for bed rail use.

4. Resident #023 was identified during their sleep observation in 2016, to have had agitation or restlessness while in bed and needed help getting out of bed.

The plan of care further included that the resident was not able to physically help to move in bed, required total assistance with bed mobility with one or two staff and required a mechanical lift and total assistance for transfers out of bed. The resident was therefore unable to use the bed rails independently.

The most current BRRA form included information that the resident needed both bed rails for a sense of security, for turning in bed and for getting in and out of bed. The assessment did not appear to be in line with the plan of care. Under the concerns section on the BRRA form, where the RPN was required to document what was discovered during the sleep observation study, only one risk factor was selected, that the resident needed assistance getting in and out of bed. The agitation and restlessness concerns were not re-assessed and it was unclear whether that particular risk factor was still an issue. Under another section, the resident was identified as being at risk of falling out of bed due to medications, could not get out of bed without assistance and was not able to ambulate without assistance and would not qualify for bed rail use. The bed rails were left in place with the insistence of the SDM/POA.

5. Resident #024 was identified during their sleep observation in 2016, to have had agitation or was restless while in bed, slept on edge of bed, needed help to get out of bed, tried to get out of bed without using the call bell for assistance and had uncontrolled body movements at least once during the observation

period.

The plan of care included that they were at high risk of falls, had dementia, required extensive assistance by two staff for bed mobility (therefore the resident could not use the bed rails independently) and included that the "Power of Attorney wanted rails up at all times".

The BRRA form included information that the resident needed bed rails for a sense of security, to turn in bed and to help get in and out of bed. The assessment did not appear to be in line with the plan of care. Under the concerns section of the BRRA form, where the RPN was required to document what was discovered during the sleep observation, only one risk factor was selected, that the resident needed assistance getting in and out of bed. . The agitation and restlessness, body movements, sleeping on the edge of the bed concerns were not re-assessed and it was unclear whether these particular risk factors were still an issue. Further, the RPN selected that the resident was at risk of falling out of bed, and could not get out of bed independently and that the resident did not qualify for bed rail use.

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

This Compliance Order is based upon three factors, severity, scope and the licensee's compliance history in keeping with section 299(1) of the Long Term Care Home Regulation 79/10. In respect to severity, there is potential for actual harm (2), for scope, the number of residents who have not been adequately assessed is widespread (3) and previous non-compliance (4) related to bed safety was issued as a Compliance Order under the same section on June 1, 2016. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 09, 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

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 9th 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 : NICOLE RANGER

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