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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jun 27, 2019	2019_745690_0002 (A1)	000877-19	Critical Incident System

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

Coleman Care Centre
140 Cundles Road West BARRIE ON L4N 9X8

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

Amended by STEPHANIE DONI (681) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested and been granted an extension for compliance order #001.

Issued on this 27th day of June, 2019 (A1)

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

Inspection Report under *the Long-Term Care Homes Act, 2007*

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

Amended by STEPHANIE DONI (681) - (A1)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 29-February 1, 2019.

The following intake was inspected during this Critical Incident Inspection:

-One intake, which was related to a critical incident the home submitted to the Director regarding an injury that resulted in a transfer to hospital.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Neighbourhood Coordinator, Kinesiologist, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents, and family members.

During the course of the inspection, the inspector(s) conducted observations in resident home areas, observation of care delivery processes, review of the home's policies and procedures, and residents' health records.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Minimizing of Restraining
Safe and Secure Home

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

2 WN(s)
0 VPC(s)
2 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	Légende 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, the resident was assessed and that the residents' bed systems were evaluated in accordance with prevailing practices to minimize risk to the resident.

A Critical Incident (CI) report was submitted to the Director on an identified date, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. The CI report identified that resident #001 sustained an injury involving their bed system.

On August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was expected to be used as the best practice document in LTC Homes and provided clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included the title of a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006". The guide included information with respect to the various options and corrective strategies available to mitigate entrapment zones, a guide to buying beds, how to inventory bed systems and reviews the dimensional criteria of bed systems. The

documents were considered prevailing practices, which were predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

In July 2018, the licensee commissioned an external company to complete an evaluation of all 111 beds in the home for entrapment zones one through four. These zones are specifically located in and around the bed rail. The auditor identified 26 bed systems that failed one or more entrapment zones. Recommendations were made to tighten certain bed rails and/or replace the mattress. The Director of Nursing Care (DNC) confirmed on January 31, 2019, that all of the bed systems had passed entrapment, that all rails were tightened on August 17, 2018, and that some mattresses were replaced. The documentation kept by the licensee with respect to bed system changes after July 25, 2018, was limited.

During the inspection, Inspector #120 reviewed the results of the bed system evaluations, and it was suspected that the auditor did not follow the procedures identified in the HCG document.

A.The auditor tested and passed zones two to four for approximately 11 beds that were equipped with only one bed rail on the bed, five of which had no mattress keepers. These five beds were all identified as having passed zones two to four. According to HCG, a bed rail or mattress keeper on the opposite side of the bed being tested would need to be in place in order for a bed to pass entrapment zones two to four. The mattress must be pushed away from the rail being tested until it comes to a full stop on the opposite side. Without a bed rail or mattress keeper on the opposite side, the procedure cannot be completed.

During the inspection, numerous beds were observed by the Inspectors to be missing mattress keepers. The auditor's evaluation results included 34 beds with missing mattress keepers. Residents in eight identified rooms did not have mattress keepers on their beds, the beds had at least one bed rail on the beds, applied in the "up" position or in the "guard" position. Shifting mattresses in and around the existing bed rails that could open up gaps were reported as a concern to the DNC at the time of the Inspection.

B.The auditor failed to identify zone four issues with a three quarter length bed rail in three identified rooms. The bed rail had rounded ends which typically fail with any type of flat mattress. During the inspection, on an identified date, the bed rail

in one of the identified rooms was re-evaluated by RN #107 with a flat mattress and failed zone four. The other four beds with the same model of bed rail were identified to have failed zone four by the auditor.

C.The auditor failed to evaluate 42 bed systems with a rotating assist rail, a type of bed rail that rotated 180 degrees. The bed rail was designed to lock and stop in two main positions, a transfer position (vertical) and a guard position (horizontal). The transfer position offered the resident the ability to get in and out of bed easily and the guard position was designed to assist residents with bed repositioning while in bed and provide a bed edge reminder. According to the HCG, bed rails must be evaluated with the cone and cylinder tool in all available locking positions.

D. The auditor evaluated four bed systems with a specified mattress in four identified rooms. The bed system failed zone two in one identified room which had a loose rotating assist rail. The other three beds either had no bed rails, a quarter length bed rail or a tightened rotating assist rail. Noted during the inspection, the mattresses had been re-distributed to other bed frames. One specified mattress was observed on an identified bed and had soft air filled cells along the width of the mattress, centrally located. When the bed system was re-evaluated on an identified date, zone three did not pass when the rotating bed rail was applied into the guard position.

The above concerns were raised by Inspector #120 with the DNC and two other staff members who were involved in evaluating the bed systems. The DNC, who acknowledged taking the lead in establishing the bed evaluation process in the home, was not aware of the various HCG requirements when evaluating beds and relied on the results provided by the external company auditor. According to the DNC, a representative of the external company provided hands on training in using the cone and cylinder tool with various staff members in the home. Throughout the year, when bed system changes were made, such as adding a new mattress, or swapping mattresses from bed to bed, the trained staff conducted the evaluations themselves, as they were trained. Concerns were raised by the DNC that they may not have adequately assessed the beds based on the knowledge they received during the inspection.

The licensee therefore did not evaluate the residents' bed systems, where bed rails were used, in accordance with prevailing practices, to minimize risk to the resident. [s. 15. (1) (a)]

2. A. Inspector #690 reviewed the above mentioned CI report and conducted a review of electronic progress notes for resident #001; which identified that a referral had been sent on an identified date (prior to the CI report), that indicated that an incident occurred involving resident #001 and their bed system, and staff were requesting additional interventions to be implemented. The referral further indicated a response by the Kinesiologist of the home that indicated that the requested intervention was not appropriate and would pose a risk to resident #001. Inspector #690 could not locate any other progress notes related to the incident mentioned in the referral.

In an interview with Inspector #690, Personal Support Worker (PSW) #109 indicated that they were working on a specific shift on the day of the incident, and that they discovered resident #001 at the time of the incident. PSW #109 further indicated that they called Registered Practical Nurse (RPN) #108 to assist with them in response to the incident.

In an interview with RPN #108, they indicated that they were called to resident #001's room by PSW #109 on the identified date and described to the inspector how they observed the resident. RPN #108 indicated that they assisted PSW #109 in responding to the identified incident. RPN #108 also indicated that they did not document a progress or incident note, that they only sent the electronic referral to request an identified intervention as they thought that it would prevent further incidences from occurring.

In an interview with Inspector #690, the Kinesiologist indicated that they had received the referral to request the identified intervention for resident #001, but that they did not assess resident #001 and they did not report the incident to anyone. The Kinesiologist further indicated that they responded in the referral that the identified requested intervention was not appropriate and would pose a greater risk to resident #001.

In a review of the home's policy titled "Bed Entrapment & Bedrail Assessment #06 -02" under the heading "Entrapment Incident or Near-Miss", it indicated that in the event that the resident had an incidence of entrapment, near-miss or injury related to rails, both the Resident Bed Rail Assessment and the Equipment Assessment must be completed, and a plan put into place to mitigate further risk of injury.

In an interview with Inspector #690, the DNC indicated that they were aware of

the referral and the request for the identified intervention and that the home did not complete the two required assessments following the identified incident and they should have.

B. A further review of resident #001's electronic progress notes, identified an incident note documented 10 days following the incident mentioned in the referral, that indicated that resident #001 was found in a similar situation and had sustained an injury and was transferred to the hospital for assessment.

A review of resident #001's electronic care plan identified a specified focus for a Personal Assistance Services Device (PASD) use which indicated that the resident had a specified PASD for an identified use while in bed.

A review of resident #001's electronic PASD assessments on Point Click Care (PCC) indicated that staff had completed a PASD assessment on the day of admission to the home. The PASD assessment indicated that resident #001 had an identified PASD in place at specified times. The PASD assessment further indicated that specified risk factors had not been considered as required. The PASD assessment also indicated that resident #001 had not been assessed without the specified PASD or with a less restrictive device. Four subsequent PASD assessments completed did not include consideration into risk factors or that the resident was assessed without the PASD or that any alternatives to the use of the PASD had been attempted.

In an interview with Inspector #690, PSW #104 indicated that resident #001 had always had the specified PASD in place and used the PASD for performing a specified activity of daily living (ADL), but that the resident had a change in their health status and was no longer able to perform the specified ADL. PSW #104 further indicated that they were not involved in the assessment of residents related to the use of the specified PASD and they did not observe residents for risk factors prior to the use of the specified PASD.

In an interview with RPN #112, they indicated that resident #001 had a specified PASD in place and had required them to preform a specified ADL. RPN #112 indicated that they were responsible for completing the PASD assessments on a quarterly basis and that part of their assessment was to consider the effectiveness of the identified PASD, whether the device could be removed and that they would look at risk factors associated with the use of the identified device. RPN #112 could not recall resident #001 not ever having the identified PASD in

place or being assessed without the device. Together Inspector #690 and RPN #112 reviewed the last five quarterly PASD assessments for resident #001. RPN #112 indicated that the PASD assessments were not completed in entirety as several areas were blank and that the assessments should have been completed fully. [s. 15. (1) (a)]

3. Resident #003's bed was observed to have two identified PASDs in place.

A review of resident #003's care plan by Inspector #690, identified a focus for PASD use that indicated that the resident had two identified PASDs in place to assist with identified ADLs.

A review of resident #003's last three quarterly PASD assessments indicated that the identified PASD assessments were not fully completed and did not include consideration of specified risk factors. The assessments also indicated that resident #003 had not been assessed without the PASDs or that alternatives had been tried.

In an interview with PSW #105, they indicated that resident #003 used the PASDs for assistance with specified ADLs. PSW #105 could not recall resident #003 not ever having the PASDs in place.

In an interview with RN #107, they indicated that resident #003 had two PASDs in place that they used for performing specified ADLs. RN #107 indicated that they did not recall the resident not ever having the PASDs. Together, Inspector #690 and RN #107 reviewed the last three quarterly PASD assessments for resident #003, RN #107 indicated that the assessments were not fully completed as the considerations into the risk factors and previous alternatives that were tried was blank, and that it would be the expectation that all sections of the assessments were completed. [s. 15. (1) (a)]

4. Resident #004's bed was observed to have two PASDs.

A review of resident #004's care plan by Inspector #690, indicated that the resident required a specified level of assistance by staff for performing a specified ADL, that the resident was unable to assist with the specified ADL and that resident #004 was not at risk of falling from the bed. The care plan further indicated that resident #004 had two PASDs to be used at specified times.

A review of resident #004's last three quarterly PASD assessments and the Alternatives to PASD/Restraint Assessment indicated that the PASDs were in place for a specified reason. The PASDs were considered a restraint. The assessments were not fully completed and did not include consideration of risk factors. The assessments also indicated that resident #004 had not been assessed without the PASDs or that the resident had not been assessed with a less restrictive device.

In an interview with Inspector #690, PSW #104 indicated that resident #004 required a specified level of assistance for a specified ADL. PSW #104 indicated that they did not know why resident #004 still had the PASDs in place as they no longer used them to perform the specified ADL. PSW #104 could not recall resident #004 not ever having the PASDs or any other alternatives being tried in place of the PASDs.

In an interview with RPN #112, they indicated that resident #004 did not use the PASDs and that they did not know why resident #004 still had the PASDs in place. They indicated that the PASDs were considered a restraint and they could not recall resident #004 ever having the PASDs removed. Together Inspector #690 and RPN #112 reviewed the last three quarterly PASD assessments and Alternative to PASD/Restraint assessments for resident #004. RPN #112 indicated that the assessments were not fully completed as the considerations into the risk factors and previous alternatives that were tried was blank, and that it would be the expectation that all sections of the assessments were completed.

A review of the home's policy titled "Restraint and PASD Procedures in LTC #04-52", last updated August 20, 2018, indicated that if a PASD had restraining effects, that alternatives would be considered and where the alternative was deemed ineffective, the least restrictive device would be used. The policy also indicated that PASD devices may be used if the device was used to assist a resident with a routine Activity of Daily Living (ADL) and was removed once the ADL was complete, unless requested by the resident, alternatives had been considered and tried where appropriate, but deemed ineffective and the device was reasonable and was the least restrictive. The physical device (restraint or PASD) must be discontinued if the device was no longer required.

In an interview with Inspector #690, the DNC indicated that it was the expectation that the resident was reassessed for the use of PASDs at least quarterly, including assessing any of the risk factors involved, any alternatives that were

tried, and if the PASD was still necessary, using the assessment on PCC. Together the DNC and Inspector #690 reviewed the PASD assessments for residents #001, #003, and #004. The DNC indicated that the assessments were not completed fully and that they should have been. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 001

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provide direct care to the resident.

Resident #002 was observed by Inspector #690 with two PASDs on their bed. Inspector #690 observed resident #002 utilizing the PASDs to perform a specified ADL.

A review of resident #002's electronic care plan, indicated that the resident required a specified level of assistance by staff for performing the specified ADL and that resident #002 was unable to assist with the specified ADL. A further review of the care plan identified that resident #002 had a focus for PASD use that indicated that they had two PASDs in place to assist resident #002 in performing a specified ADL.

A review of resident #002's last three quarterly PASD assessments identified that the resident had two PASDs in place and indicated that resident #002 utilized the PASDs to assist them with performing a specified ADL.

In an interview with Inspector #690, PSW #105 indicated that resident #005 was capable of using the PASDs to assist with performing the ADL and that they used them often.

In an interview with RN #107, they indicated that resident #002 had two PASDs in place and that they used them to assist with performing a specified ADL. Together, Inspector #690 and RN #107 reviewed resident #002's care plan on Point Click Care (PCC), RN #107 indicated that the care plan identified that resident #002 had PASDs, and that they could use them. RN #107 further indicated that under a different identified focus, the care plan indicated that the resident could not assist with performing the specified ADL using the PASDs. RN #107 indicated that staff would use the care plan to identify what care and assistance a resident required and that it should provide clear direction to staff and that resident #002's care plan did not provide clear direction.

In an interview with the DNC, they indicated that the care plan should provide clear direction and that resident #002's care plan did not provide staff with clear direction. [s. 6. (1) (c)]

2. Resident #003 was observed by Inspector #690, with two PASDs on their bed.

A review of resident #003's electronic care plan, indicated that the resident required assistance for performing a specified ADL and that resident #003 was unable to assist with performing the specified ADL. A further review of the care plan identified that resident #003 had a focus for PASD use that indicated that they had two PASDs in place and that they used them to assist with performing the specified ADL.

A review of resident #003's last three quarterly PASD assessments identified that the resident had two PASDs and indicated that resident #003 utilized the PASDs for assisting with specified ADLs.

In an interview with Inspector #690, PSW #106 indicated that resident #003 used the PASDs to perform specified ADLs and that they were capable of using the PASDs to perform the specified ADLs.

In an interview with RN #107, they indicated that resident #003 had two PASDs that they used to perform a specified ADL.Together, Inspector #690 and RN #107 reviewed resident #003's care plan on PCC and RN #107 indicated that the care plan identified that resident #003 had the PASDs and would use them. RN #107 further indicated that under a different identified focus, the care plan indicated that the resident could not assist with performing the specified ADL. RN #107 indicated that staff would use the care plan to identify what care and assistance a resident required and that it should provide clear direction to staff and that resident #003's care plan did not provide clear direction.

In an with the DNC, they indicated that the care plan should provide clear direction and that resident #003's care plan did not provide staff with clear direction. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the care set out in the plan of care had not been effective.

Inspector #690 reviewed a CI report submitted on an identified date, to the Director for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status. Please refer to WN #1, finding 1, for details.

Inspector #690 reviewed resident #001's electronic progress notes and identified that the resident had experienced an identified number of falls in the quarter prior to the incident attempting to perform a specified ADL.

Inspector #690 reviewed resident #001's electronic care plan and could not identify any revisions to the falls prevention interventions in the quarter prior to the above mentioned incident.

A review of the home's policy titled "Falls Prevention and Management Program (LTC) 04-33, last revised on August 20, 2018, indicated that the Registered Nursing Team were to monitor and evaluate the care plan quarterly and as required in collaboration with the interprofessional team and if the strategies were not effective in reducing falls, staff were to initiate alternative approaches and update as necessary.

In an interview with Inspector #690, PSW #104 indicated that resident #001 frequently attempted to perform the specified ADL and had sustained falls. PSW #104 indicated that they would find information on a resident's falls prevention interventions on the care plan on PCC.

In an interview with Inspector #107, RN #107 indicated that resident #001 had an identified number of falls in the quarter prior to the incident on the identified date. RN #107 further indicated that resident #001 was known to attempt to perform the specified ADL but that they were no longer able to do so safely. RN #107 identified that it was the responsibility of the registered staff to review a resident's fall prevention interventions after a fall and to revise the care plan on PCC if the interventions were no longer effective. Together, Inspector #690 and RN #107 reviewed resident #001's care plan. RN #107 indicated that the falls prevention interventions on resident #001's care plan were not effective, that there had been no revisions to the interventions following the identified number of falls. RN #107 further indicated that the falls prevention interventions were not revised until after the incident that occurred on the identified date and that there should have been revisions after the falls that occurred prior to the above mentioned incident.

In an interview with Inspector #690, the DNC indicated that registered staff were to reassess the resident and revise the falls prevention interventions on the care plan if the interventions were not effective. The DNC went on to state that resident #001's falls prevention interventions were not effective in preventing further falls

and that there should have been revisions to the interventions following the falls.
[s. 6. (11) (b)]

Issued on this 27th day of June, 2019 (A1)

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

Ministère de la Santé et des Soins de longue durée

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by STEPHANIE DONI (681) - (A1)
Inspection No. / No de l'inspection :	2019_745690_0002 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000877-19 (A1)
Type of Inspection / Genre d'inspection :	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jun 27, 2019(A1)
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	Coleman Care Centre 140 Cundles Road West, BARRIE, ON, L4N-9X8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Michelle Uprichard

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

To Schlegel Villages 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)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s.15(1)(a) of O. Reg. 79/10.

Specifically, the licensee must:

1. a) Re-evaluate all bed systems in the home using the weighted cone and cylinder tool in accordance with "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards ", March 2008. Specifically, the bed systems are to be evaluated for zones 2, 3 and 4, and for beds with rotating assist rails, the bed rails are to be evaluated in both the transfer (vertical position) and in the guard (horizontal) position.

b) Where one or more bed rails will be applied or attached to a bed frame, equip the bed frame with mattress keepers that will keep the mattress from sliding side to side, and will allow the mattress to fit properly between the keepers (mattresses must not sit on top of the keepers).

c) Where bed rails do not pass zone 2, 3 or 4, mitigate the bed system in accordance with "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" or equip the bed systems with a different

manufacturer's compatible bed mattress or bed rail that passes zones 1 to 4.

d) Inspect each bed when conducting bed system evaluations for condition as per the manufacturer's recommendations (castor brakes, remote, manual cranks, head and foot board condition, mattress condition, bed rail condition).

e) Educate all bed system evaluators on the requirements of the Health Canada guidelines entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, March 2008" and "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006).

f) Make available the results of the bed system re-evaluation to the interdisciplinary team who participates in assessing each resident for bed rail safety.

g) Keep accurate and detailed records as to what was done to a bed once it is initially evaluated (i.e. what specific change was made to the bed, the date the change was made, bed and mattress identifier, who made the changes, the re-evaluation date, auditor name and results).

h) Amend or update policy 06-02 entitled "Bed Entrapment and Bedrail Assessment" to include a reference to "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment". (U.S. FDA June 21, 2006) and any additional information and guidance for bed system evaluators for a thorough evaluation.

Grounds / Motifs :

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

A Critical Incident (CI) report was submitted to the Director on an identified date, for an incident that caused an injury to a resident for which the resident was taken to hospital and which resulted in a significant change in the resident's health status.

The CI report identified that resident #001 sustained an injury involving their bed system.

On August 21, 2012, a notice was issued to the Long Term Care Home (LTC) Administrators from the Director of the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch, identifying a document produced by Health Canada entitled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008". The document was expected to be used as the best practice document in LTC Homes and provided clear procedures and dimensional criteria with respect to evaluating bed systems using a cone and cylinder tool. The Health Canada Guidance (HCG) document also included the title of a companion guide developed by the Food and Drug Administration (FDA) in the United States entitled "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment, 2006". The guide included information with respect to the various options and corrective strategies available to mitigate entrapment zones, a guide to buying beds, how to inventory bed systems and reviews the dimensional criteria of bed systems. The documents were considered prevailing practices, which were predominant, generally accepted widespread practice as the basis for clinical decisions with respect to bed safety.

In July 2018, the licensee commissioned an external company to complete an evaluation of all 111 beds in the home for entrapment zones one through four. These zones are specifically located in and around the bed rail. The auditor identified 26 bed systems that failed one or more entrapment zones. Recommendations were made to tighten certain bed rails and/or replace the mattress. The Director of Nursing Care (DNC) confirmed on January 31, 2019, that all of the bed systems had passed entrapment, that all rails were tightened on August 17, 2018, and that some mattresses were replaced. The documentation kept by the licensee with respect to bed system changes after July 25, 2018, was limited.

During the inspection, Inspector #120 reviewed the results of the bed system evaluations, and it was suspected that the auditor did not follow the procedures identified in the HCG document.

A.The auditor tested and passed zones two to four for approximately 11 beds that were equipped with only one bed rail on the bed, five of which had no mattress

keepers. These five beds were all identified as having passed zones two to four. According to HCG, a bed rail or mattress keeper on the opposite side of the bed being tested would need to be in place in order for a bed to pass entrapment zones two to four. The mattress must be pushed away from the rail being tested until it comes to a full stop on the opposite side. Without a bed rail or mattress keeper on the opposite side, the procedure cannot be completed.

During the inspection, numerous beds were observed by the Inspectors to be missing mattress keepers. The auditor's evaluation results included 34 beds with missing mattress keepers. Residents in eight identified rooms did not have mattress keepers on their beds, the beds had at least one bed rail on the beds, applied in the "up" position or in the "guard" position. Shifting mattresses in and around the existing bed rails that could open up gaps were reported as a concern to the DNC at the time of the Inspection.

B.The auditor failed to identify zone four issues with a three quarter length bed rail in three identified rooms. The bed rail had rounded ends which typically fail with any type of flat mattress. During the inspection, on an identified date, the bed rail in one of the identified rooms was re-evaluated by RN #107 with a flat mattress and failed zone four. The other four beds with the same model of bed rail were identified to have failed zone four by the auditor.

C.The auditor failed to evaluate 42 bed systems with a rotating assist rail, a type of bed rail that rotated 180 degrees. The bed rail was designed to lock and stop in two main positions, a transfer position (vertical) and a guard position (horizontal). The transfer position offered the resident the ability to get in and out of bed easily and the guard position was designed to assist residents with bed repositioning while in bed and provide a bed edge reminder. According to the HCG, bed rails must be evaluated with the cone and cylinder tool in all available locking positions.

D. The auditor evaluated four bed systems with a specified mattress in four identified rooms. The bed system failed zone two in one identified room which had a loose rotating assist rail. The other three beds either had no bed rails, a quarter length bed rail or a tightened rotating assist rail. Noted during the inspection, the mattresses had been re-distributed to other bed frames. One specified mattress was observed on an identified bed and had soft air filled cells along the width of the mattress, centrally located. When the bed system was re-evaluated on an identified date, zone

three did not pass when the rotating bed rail was applied into the guard position.

The above concerns were raised by Inspector #120 with the DNC and two other staff members who were involved in evaluating the bed systems. The DNC, who acknowledged taking the lead in establishing the bed evaluation process in the home, was not aware of the various HCG requirements when evaluating beds and relied on the results provided by the external company auditor. According to the DNC, a representative of the external company provided hands on training in using the cone and cylinder tool with various staff members in the home. Throughout the year, when bed system changes were made, such as adding a new mattress, or swapping mattresses from bed to bed, the trained staff conducted the evaluations themselves, as they were trained. Concerns were raised by the DNC that they may not have adequately assessed the beds based on the knowledge they received during the inspection.

The licensee therefore did not evaluate the residents' bed systems, where bed rails were used, in accordance with prevailing practices, to minimize risk to the resident.

The severity of this issue was determined to be a level three, as there was actual harm. The scope of the issue was a level three, as the number of bed systems that were not evaluated in accordance with prevailing practice was widespread. The home had a level one compliance history, as they had no previous compliance history with this section of the Ontario Regulation 79/10. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 2019(A1)

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

The licensee must be compliant with s.15(1)(a) of O. Reg. 79/10.

Specifically, the licensee must:

1. Amend the home's existing process related to resident clinical assessments and the use of bed rails to include additional guidance related to bed safety hazards found in the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes and Home Care Settings", (U.S. F.D.A, April 2003) which is recommended as the prevailing practices for individualized resident assessment of bed rails. The amended process shall, at a minimum, include a process related to the following:

a. the observation of the resident while sleeping for a specified period of time, to establish their bed mobility status, medical condition, medication use, behaviours and any other relevant risk factors prior to the application of any bed rail or bed system accessory (bed remote control) or alternative to bed rails (bolster, positioning rolls, roll guards);

b. the observation and documentation of the resident while sleeping for a specific period of time, to establish any safety risks to the resident after a bed rail, accessory or alternative has been applied and deemed necessary; and

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

2. Ensure that all registered staff who participate in the assessment of residents where bed rails are used shall have an understanding of and be able to apply expectations identified in both the "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other hazards, 2006", and the "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings", U.S. F.D.A, April 2003, in order to establish and document the rationale for or against the implementation of bed rails as it relates to safety risks.

3. Provide training to all relevant staff who participate in the assessment and observation of residents to establish any safety risks related to the use of bed rails and maintain a record of attendance.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, the resident had been assessed and his or her bed system was evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

A. Inspector #690 reviewed the above mentioned CI report and conducted a review of electronic progress notes for resident #001; which identified a referral had been sent on an identified date (prior to the CI report), that indicated that an incident occurred involving resident #001 and their bed system, and staff were requesting additional interventions to be implemented. The referral further indicated a response by the Kinesiologist of the home that indicated that the requested intervention was not appropriate and would pose a risk to resident #001. Inspector #690 could not locate any other progress notes related to the incident mentioned in the referral.

In an interview with Inspector #690, Personal Support Worker (PSW) #109 indicated

that they were working on a specific shift on the day of the incident, and that they discovered resident #001 at the time of the incident. PSW #109 further indicated that they called Registered Practical Nurse (RPN) #108 to assist with them in response to the incident.

In an interview with RPN #108, they indicated that they were called to resident #001's room by PSW #109 on the identified date described to the inspector how they observed the resident. RPN #108 indicated that they assisted PSW #109 in responding to the identified incident. RPN #108 also indicated that they did not document a progress or incident note, that they only sent the electronic referral to request an identified intervention as they thought that it would prevent further incidences from occurring.

In an interview with Inspector #690, the Kinesiologist indicated that they had received the referral to request the identified intervention for resident #001, but that they did not assess resident #001 and they did not report the incident to anyone. The Kinesiologist further indicated that they responded in the referral that the identified requested intervention was not appropriate and would pose a greater risk to resident #001.

In a review of the home's policy titled "Bed Entrapment & Bedrail Assessment #06-02" under the heading "Entrapment Incident or Near-Miss", it indicated that in the event that the resident had an incidence of entrapment, near-miss or injury related to rails, both the Resident Bed Rail Assessment and the Equipment Assessment must be completed, and a plan put into place to mitigate further risk of injury.

In an interview with Inspector #690, the DNC indicated that they were aware of the referral and the request for the identified intervention and that the home did not complete the two required assessments following the identified incident and they should have.

B. A further review of resident #001's electronic progress notes, identified an incident note documented 10 days following the incident mentioned in the referral, that indicated that resident #001 was found in a similar situation and had sustained an injury and was transferred to the hospital for assessment.

A review of resident #001's electronic care plan identified a specified focus for a

Personal Assistance Services Device (PASD) use which indicated that the resident had a specified PASD for an identified use while in bed.

A review of resident #001's electronic PASD assessments on Point Click Care (PCC) indicated that staff had completed a PASD assessment on the day of admission to the home. The PASD assessment indicated that resident #001 had an identified PASD in place at specified times. The PASD assessment further indicated that specified risk factors had not been considered as required. The PASD assessment also indicated that resident #001 had not been assessed without the specified PASD or with a less restrictive device. Four subsequent PASD assessments completed did not include consideration into risk factors or that the resident was assessed without the PASD or that any alternatives to the use of the PASD had been attempted.

In an interview with Inspector #690, PSW #104 indicated that resident #001 had always had the specified PASD in place and used the PASD for performing a specified activity of daily living (ADL), but that the resident had a change in their health status and was no longer able to perform the specified ADL. PSW #104 further indicated that they were not involved in the assessment of residents related to the use of the specified PASD and they did not observe residents for risk factors prior to the use of the specified PASD.

In an interview with RPN #112, they indicated that resident #001 had a specified PASD in place and had required them to preform a specified ADL. RPN #112 indicated that they were responsible for completing the PASD assessments on a quarterly basis and that part of their assessment was to consider the effectiveness of the identified PASD, whether the device could be removed and that they would look at risk factors associated with the use of the identified device. RPN #112 could not recall resident #001 not ever having the identified PASD in place or being assessed without the device. Together Inspector #690 and RPN #112 reviewed the last five quarterly identified assessments for resident #001. RPN #112 indicated that the identified assessments were not completed in entirety as several areas were blank and that the assessments should have been completed fully. (690)

2. Resident #003's bed was observed to have two identified PASDs in place.

A review of resident #003's care plan by Inspector #690, identified a focus for PASD use that indicated that the resident had two identified PASDs in place to assist with identified ADLs.

A review of resident #003's last three quarterly PASD assessments indicated that the identified PASD assessments were not fully completed and did not include consideration of specified risk factors. The assessments also indicated that resident #003 had not been assessed without the PASDs or that alternatives had been tried.

In an interview with PSW #105, they indicated that resident #003 used the PASDs for assistance with specified ADLs. PSW #105 could not recall resident #003 not ever having the PASDs in place.

In an interview with RN #107, they indicated that resident #003 had two PASDs in place that they used for performing specified ADLs. RN #107 indicated that they did not recall the resident not ever having the PASDs. Together, Inspector #690 and RN #107 reviewed the last three quarterly PASD assessments for resident #003, RN #107 indicated that the assessments were not fully completed as the considerations into the risk factors and previous alternatives that were tried was blank, and that it would be the expectation that all sections of the assessments were completed. (690)

3. Resident #004's bed was observed to have two PASDs.

A review of resident #004's care plan by Inspector #690, indicated that the resident required a specified level of assistance by staff for performing a specified ADL, that the resident was unable to assist with the specified ADL and that resident #004 was not at risk of falling from the bed. The care plan further indicated that resident #004 had two PASDs to be used at specified times.

A review of resident #004's last three quarterly PASD assessments and the Alternatives to PASD/Restraint Assessment indicated that the PASDs were in place for a specified reason. The PASDs were considered a restraint. The assessments were not fully completed and did not include consideration of risk factors. The assessments also indicated that resident #004 had not been assessed without the PASDs or that the resident had not been assessed with a less restrictive device.

In an interview with Inspector #690, PSW #104 indicated that resident #004 required a specified level of assistance for a specified ADL. PSW #104 indicated that they did not know why resident #004 still had the PASDs in place as they no longer used them to perform the specified ADL. PSW #104 could not recall resident #004 not ever having the PASDs or any other alternatives being tried in place of the PASDs.

In an interview with RPN #112, they indicated that resident #004 did not use the PASDs and that they did not know why resident #004 still had the PASDs in place. They indicated that the PASDs were considered a restraint and they could not recall resident #004 ever having the PASDs removed. Together Inspector #690 and RPN #112 reviewed the last three quarterly PASD assessments and Alternative to PASD/Restraint assessments for resident #004. RPN #112 indicated that the assessments were not fully completed as the considerations into the risk factors and previous alternatives that were tried was blank, and that it would be the expectation that all sections of the assessments were completed.

A review of the home's policy titled "Restraint and PASD Procedures in LTC #04-52", last updated August 20, 2018, indicated that if a PASD had restraining effects, that alternatives would be considered and where the alternative was deemed ineffective, the least restrictive device would be used. The policy also indicated that PASD devices may be used if the device was used to assist a resident with a routine Activity of Daily Living (ADL) and was removed once the ADL was complete, unless requested by the resident, alternatives had been considered and tried where appropriate, but deemed ineffective and the device was reasonable and was the least restrictive. The physical device (restraint or PASD) must be discontinued if the device was no longer required.

In an interview with Inspector #690, the DNC indicated that it was the expectation that the resident was reassessed for the use of PASDs at least quarterly, including assessing any of the risk factors involved, any alternatives that were tried, and if the PASD was still necessary, using the assessment on PCC. Together the DNC and Inspector #690 reviewed the PASD assessments for residents #001, #003, and #004. The DNC indicated that the assessments were not completed fully and that they should have been.

The severity of this issue was determined to be a level three, as there was actual harm. The scope of the issue was a level three, as the number of incomplete bed rail

assessments was widespread. The home had a level one compliance history, as they had no previous compliance history with this section of the Ontario Regulation 79/10. (690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

The written request for review must be served personally, by registered mail, 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:

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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 27th day of June, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by STEPHANIE DONI (681) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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