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 le Loi de 2007 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**

Ottawa Service Area Office
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# Amended Public Copy/Copie modifiée du public de permis

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 10, 2018; | 2018_625133_0013 (A1) | 029355-17 | Follow up |

## Licensee/Titulaire de permis

Arnprior Regional Health
350 John Street North ARNPRIOR ON K7S 2P6

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

The Grove, Arnprior and District Nursing Home
275 Ida Street North ARNPRIOR ON K7S 3M7

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

Amended by JESSICA LAPENSEE (133) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The compliance due date (CDD) for compliance order #001, related to bed rail use, has been amended in response to a request from the licensee. The CDD was originally September 26, 2018. The CDD is now November 30, 2018.**

**Issued on this 10 day of September 2018 (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**

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

Amended by JESSICA LAPENSEE (133) - (A1)

## Amended Inspection Summary/Résumé de l'inspection modifié

**The purpose of this inspection was to conduct a Follow up inspection.**

**This inspection was conducted on the following date(s): June 7, 8, 2018**

**The inspection was in follow up to to Compliance Order (CO) #001 issued as a result of inspection #2017_593573_0026, related to bed rail use. The CO was reissued as a result of this Follow Up inspection.**

**During the course of the inspection, the inspector(s) spoke with the Vice President of Patient/Resident Services and Chief Nurse Executive, the Director of Care, the RAI coordinator, a Registered Practical Nurse and a maintenance worker.**

**During the course of the inspection, the Inspector observed residents in bed and residents' bed systems, observed a demonstration of entrapment zone testing on an identified resident's bed system, reviewed identified resident's health care records and reviewed resident assessment documents related to bed rail use.**

**The following Inspection Protocols were used during this inspection:**

**Safe and Secure Home**

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.<br><br>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 comply with compliance order (CO) #001 from inspection #2017_593573_0026. The CO was originally served on December 21, 2017, with a compliance date of March 21, 2018. The CO was amended, as per request from the licensee, on March 13, 2018. The amendment was in relation to the compliance date, which was extended to April 6, 2018.

The licensee was ordered to:

1. Ensure that an interdisciplinary team assess all residents in the home with one or more bed rails in use, in accordance with the 2003 FDA prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings". The resident's assessment shall include all factors, elements and conditions as outlined in the prevailing practices document.

2. Re-evaluate all resident's bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident.

3. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment.

4. Ensure that the above assessments are documented including the names of team members participating in the assessment, the results of the assessment including the risk benefit assessment, and the recommendations. Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team.

The licensee completed step 3 in CO #001

The licensee failed to complete steps 1, 2 and 4 in CO #001.

Related to the assessment of residents with one or more bed rails in use:

On June 7, 2018, the Inspector met with the Vice President of Patient/Resident Services and Chief Nurse Executive (#102), the Director of Care (#103), and the RAI coordinator (#104) to review the home's resident assessment process related to bed rail use. The Inspector was informed that new resident assessment forms, titled "Evaluation for use of bed rails", and the associated form titled "Informed consent for use of bed rails", had been put into use in response to the compliance order. Upon a resident's admission to the home, the forms are to be filled out by the Registered Practical Nurse (RPN) that is conducting the admission process. The RPN, and not an interdisciplinary team, approves the use bed rails upon the resident's admission. There is to be a subsequent team review of the completed forms and discussion about a resident's use of bed rails, at the 14 day Resident Assessment Protocol (RAP) meeting.

On June 8, 2018, six residents (#001 - #006) with bed rails in use were selected by the Inspector for follow up with regards to the home's new assessment process related to bed rail use. Resident #001's health care record was reviewed and an "Evaluation for use of bed rails" form was located. The "Informed consent for use of bed rails" form was not found. The evaluation form was incomplete, in that only the resident's height, sleeping status and recommended type of bed rails were noted. The questions related to additional considerations and risk factors, for example, had not been answered. Resident #002 - #006's health care records were subsequently reviewed and the Inspector could not locate either of the assessment forms, for the five resident. The Director of Care (DOC) was informed of the incomplete and missing assessment forms. The DOC confirmed that they had found that the residents did not have an assessment in place, and that they had directed Registered Practical Nurse (RPN) #101 to initiate the assessment process

for the residents that day.

On June 8, 2018, RPN #101 indicated to the Inspector that they had never seen the assessment forms ("Evaluation for use of bed rails" and "Informed consent for use of bed rails") before that day, and had done their best to follow the questions as they understood them. Related to mobility (in and out of bed), it was noted that the evaluation form questioned if bed rails would assist the resident in factors related to bed mobility and transfer. RPN #101 indicated that they had answered these questions, for resident #002 - #006, based on their understanding of how the residents used the bed rails that were in place. RPN #010 indicated that they could not comment on the residents' bed mobility or transfer abilities, independent of the bed rails. Related to the questions on the evaluation form regarding a decline in cognitive status and increased agitation, RPN #101 indicated that although a resident may have cognitive impairment or agitation, they answered these questions with a "no" as there had not been a decline in cognitive status or increase in agitation since the time of the resident's admission. Related to the notion of a final risk – benefit assessment, it was noted that the consent form did include a question about the possible risks of bed rail use for an individual resident. In response to this question for resident #002 - #006, RPN #101 had written either "see paragraph 2" or "see above", as opposed to capturing the resident's individual risk factors. These responses were in reference to the "potential risks and negative outcomes" section of the consent form, which described a number of potential risks related to bed rail use, including entrapment, applicable to any resident with bed rails in use. RPN #101 indicated that they did not understand what else they would write in response to this question. As per the FDA Clinical Guidance Document, the population at risk for entrapment includes residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that cause them to move about the bed or try and exit from the bed. The absence of timely toileting, position change and nursing care are factors that may also contribute to the risk of entrapment.

On June 8, 2018, the Inspector and the DOC reviewed the factors specified for a resident assessment, as per the FDA Clinical Guidance Document, versus the "Evaluation for use of bed rails" forms and the "Informed consent for use of bed rails" forms that RPN #101 had initiated for resident #002 - #006 that day. The consent form referenced the use of bed rail(s) to treat the resident's medical condition. On the evaluation form, within the section "why is the use of a bed rail(s) being considered?", the category of "Medical Diagnosis related to the evaluation

for bed rail use: " could be selected. It was noted that this would not capture the resident's complete medical diagnosis, and therefore diagnosis that may inform the final risk benefit assessment, such as a diagnosis related to cognitive impairment, would not be captured. It was noted that the evaluation form did not provide for consideration of a resident's current cognition. The only question related to cognition specifically addressed if there had been a decline in a resident's cognitive status. Similarly, it was noted that the evaluation form did not provide for consideration of the current status of a resident's symptoms, such as agitation. The only question related to agitation specifically addressed if there was increased agitation. It was noted that the evaluation form did not provide for consideration of a resident's communication abilities. It was noted that while the evaluation form included questions about continence and toileting, the resident's ability to toilet self safely, which is further defined as "ability/inability to ambulate to and from the toilet without falling", was not captured. It was noted that the assessment forms did not provide for a risk benefit assessment as per the FDA Clinical Guidance document, including a documented team determination that the risk of bed rail use was lower than that of other interventions or of not using them, if a team approved of the use of bed rails for a resident.

Related to the evaluation of residents' bed systems:

On June 7, 2018, the Inspector met with the maintenance worker (#105) who had evaluated the residents' bed systems. The maintenance worker demonstrated, on resident #007's bed, the entrapment zone testing process that they had followed, with the cone and cylinder combination tool as prescribed by the Health Canada guidance document. It was confirmed that the maintenance worker had not tested entrapment zone 2, the space under the rail between the rail supports, on the residents' bed systems. It was confirmed that entrapment zone 3, the space between the rail and the mattress, had been incorrectly tested on the residents' bed systems. The zone 3 test is to be conducted with the cone portion of the tool only. The cone is to be placed horizontally in the gap between the mattress and the inside of the rail being tested and the cone is to be turned until the line on the face of the large end is horizontal. The cone is to be allowed to sink into the space by its own weight. If the line across the flat end of the cone is above the surface of the mattress, the space passes the test. If the line across the flat end of the cone is at or below the top surface of the mattress, the space fails the test. The maintenance worker indicated that they had used the assembled cone and cylinder to perform the zone 3 test. The maintenance worker indicated that they had not been aware of the line across the flat end of the cone.

In summary, the severity of the issues identified was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issues identified was level 3 as they related to all residents' bed systems and six of the six residents reviewed. The home had a compliance history of 4 as there was ongoing non-compliance with O. Reg. 79/10, s. 15 (1):

- compliance order (CO) #001 was issued on December 21, 2017, with a compliance date of March 21, 2018. The CO was amended, as per request from the licensee, on March 13, 2018. The amendment was in relation to the compliance date, which was extended to April 6, 2018.

Consequently, a second CO pursuant to O. Reg. 79/10, s. 15 (1) will be issued to the licensee. [s. 15. (1) (a)]

***Additional Required Actions:***

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

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

**Issued on this 10 day of September 2018 (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


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## Amended Public Copy/Copie modifiée du public de permis

**Name of Inspector (ID #) / Nom de l'inspecteur (No) :** Amended by JESSICA LAPENSEE (133) - (A1)

**Inspection No. / No de l'inspection :** 2018_625133_0013 (A1)

**Appeal/Dir# / Appel/Dir#:**

**Log No. / No de registre :** 029355-17 (A1)

**Type of Inspection / Genre d'inspection:** Follow up

**Report Date(s) / Date(s) du Rapport :** Sep 10, 2018;(A1)

**Licensee / Titulaire de permis :** Arnprior Regional Health
350 John Street North, ARNPRIOR, ON, K7S-2P6

**LTC Home / Foyer de SLD :** The Grove, Arnprior and District Nursing Home
275 Ida Street North, ARNPRIOR, ON, K7S-3M7

**Name of Administrator / Nom de l'administratrice ou de l'administrateur :** Eric Hanna

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 Arnprior Regional Health, you are hereby required to comply with the following order(s) by the date(s) set out below:

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**Order # / Ordre no :** 001

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

**Linked to Existing Order / Lien vers ordre existant:** 2017_593573_0026, 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 must be compliant with O. Reg. 79/10, s. 15 (1)

Specifically the licensee must:

1) Ensure that bed rail use, for resident #001, #002, #003, #004, #005 and #006, and any other resident, is assessed and implemented in full accordance with the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003). This includes, but is not limited to:

a) A documented individual resident assessment by an interdisciplinary team, including all specified factors prior to any decision regarding bed rail use or removal from use. The specified factors are: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; sleep habits;

medication; acute medical or surgical interventions; underlying medical conditions; existence of delirium; ability to toilet self safely; cognition; communication; mobility (in and out of bed); risk of falling.

b) A documented risk benefit assessment, following the resident assessment by the interdisciplinary team, where bed rails are in use. The documented risk benefit assessment, as prescribed, is to include: identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident; a final conclusion indicating that clinical and environmental interventions have proven to be unsuccessful in meeting the resident's assessed needs or a determination that the risk of bed rail use is lower that of other interventions or of not using them.

c) Documented approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment and the final risk benefit assessment. The names of the team members are to be documented.

2) Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team. Consider the factors referenced with regards to the sleeping environment assessment, the treatment programs/care plans section and the risk intervention section of the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (FDA, 2003) when updating the written plan of care.

3) Re-evaluate all resident's bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident.

4) Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment.

**Grounds / Motifs :**

1. The licensee has failed to comply with compliance order (CO) #001 from inspection #2017_593573_0026. The CO was originally served on December 21, 2017, with a compliance date of March 21, 2018. The CO was amended, as per request from the licensee, on March 13, 2018. The amendment was in relation to the compliance date, which was extended to April 6, 2018.

The licensee was ordered to:

1. Ensure that an interdisciplinary team assess all residents in the home with one or more bed rails in use, in accordance with the 2003 FDA prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings". The resident's assessment shall include all factors, elements and conditions as outlined in the prevailing practices document.

2. Re-evaluate all resident's bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" to minimize risk to the resident.

3. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment.

4. Ensure that the above assessments are documented including the names of team members participating in the assessment, the results of the assessment including the risk benefit assessment, and the recommendations. Update the written plan of care based on the resident's assessment/ reassessment by the interdisciplinary team.

The licensee completed step 3 in CO #001

The licensee failed to complete steps 1, 2 and 4 in CO #001.

Related to the assessment of residents with one or more bed rails in use:

On June 7, 2018, the Inspector met with the Vice President of Patient/Resident

Services and Chief Nurse Executive (#102), the Director of Care (#103), and the RAI coordinator (#104) to review the home's resident assessment process related to bed rail use. The Inspector was informed that new resident assessment forms, titled "Evaluation for use of bed rails", and the associated form titled "Informed consent for use of bed rails", had been put into use in response to the compliance order. Upon a resident's admission to the home, the forms are to be filled out by the Registered Practical Nurse (RPN) that is conducting the admission process. The RPN, and not an interdisciplinary team, approves the use bed rails upon the resident's admission. There is to be a subsequent team review of the completed forms and discussion about a resident's use of bed rails, at the 14 day Resident Assessment Protocol (RAP) meeting.

On June 8, 2018, six residents (#001 - #006) with bed rails in use were selected by the Inspector for follow up with regards to the home's new assessment process related to bed rail use. Resident #001's health care record was reviewed and an "Evaluation for use of bed rails" form was located. The "Informed consent for use of bed rails" form was not found. The evaluation form was incomplete, in that only the resident's height, sleeping status and recommended type of bed rails were noted. The questions related to additional considerations and risk factors, for example, had not been answered. Resident #002 - #006's health care records were subsequently reviewed and the Inspector could not locate either of the assessment forms, for the five resident. The Director of Care (DOC) was informed of the incomplete and missing assessment forms. The DOC confirmed that they had found that the residents did not have an assessment in place, and that they had directed Registered Practical Nurse (RPN) #101 to initiate the assessment process for the residents that day.

On June 8, 2018, RPN #101 indicated to the Inspector that they had never seen the assessment forms ("Evaluation for use of bed rails" and "Informed consent for use of bed rails") before that day, and had done their best to follow the questions as they understood them. Related to mobility (in and out of bed), it was noted that the evaluation form questioned if bed rails would assist the resident in factors related to bed mobility and transfer. RPN #101 indicated that they had answered these questions, for resident #002 - #006, based on their understanding of how the residents used the bed rails that were in place. RPN #010 indicated that they could not comment on the residents' bed mobility or transfer abilities, independent of the bed rails. Related to the questions on the evaluation form regarding a decline in cognitive status and increased agitation, RPN #101 indicated that although a resident

may have cognitive impairment or agitation, they answered these questions with a "no" as there had not been a decline in cognitive status or increase in agitation since the time of the resident's admission. Related to the notion of a final risk – benefit assessment, it was noted that the consent form did include a question about the possible risks of bed rail use for an individual resident. In response to this question for resident #002 - #006, RPN #101 had written either "see paragraph 2" or "see above", as opposed to capturing the resident's individual risk factors. These responses were in reference to the "potential risks and negative outcomes" section of the consent form, which described a number of potential risks related to bed rail use, including entrapment, applicable to any resident with bed rails in use. RPN #101 indicated that they did not understand what else they would write in response to this question. As per the FDA Clinical Guidance Document, the population at risk for entrapment includes residents who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction and acute urinary retention that cause them to move about the bed or try and exit from the bed. The absence of timely toileting, position change and nursing care are factors that may also contribute to the risk of entrapment.

On June 8, 2018, the Inspector and the DOC reviewed the factors specified for a resident assessment, as per the FDA Clinical Guidance Document, versus the "Evaluation for use of bed rails" forms and the "Informed consent for use of bed rails" forms that RPN #101 had initiated for resident #002 - #006 that day. The consent form referenced the use of bed rail(s) to treat the resident's medical condition. On the evaluation form, within the section "why is the use of a bed rail(s) being considered?", the category of "Medical Diagnosis related to the evaluation for bed rail use: " could be selected. It was noted that this would not capture the resident's complete medical diagnosis, and therefore diagnosis that may inform the final risk benefit assessment, such as a diagnosis related to cognitive impairment, would not be captured. It was noted that the evaluation form did not provide for consideration of a resident's current cognition. The only question related to cognition specifically addressed if there had been a decline in a resident's cognitive status. Similarly, it was noted that the evaluation form did not provide for consideration of the current status of a resident's symptoms, such as agitation. The only question related to agitation specifically addressed if there was increased agitation. It was noted that the evaluation form did not provide for consideration of a resident's communication abilities. It was noted that while the evaluation form included questions about continence and toileting, the resident's ability to toilet self safely, which is further defined as "ability/inability to ambulate to and from the toilet without falling", was not

captured. It was noted that the assessment forms did not provide for a risk benefit assessment as per the FDA Clinical Guidance document, including a documented team determination that the risk of bed rail use was lower than that of other interventions or of not using them, if a team approved of the use of bed rails for a resident.

Related to the evaluation of residents' bed systems:

On June 7, 2018, the Inspector met with the maintenance worker (#105) who had evaluated the residents' bed systems. The maintenance worker demonstrated, on resident #007's bed, the entrapment zone testing process that they had followed, with the cone and cylinder combination tool as prescribed by the Health Canada guidance document. It was confirmed that the maintenance worker had not tested entrapment zone 2, the space under the rail between the rail supports, on the residents' bed systems. It was confirmed that entrapment zone 3, the space between the rail and the mattress, had been incorrectly tested on the residents' bed systems. The zone 3 test is to be conducted with the cone portion of the tool only. The cone is to be placed horizontally in the gap between the mattress and the inside of the rail being tested and the cone is to be turned until the line on the face of the large end is horizontal. The cone is to be allowed to sink into the space by its own weight. If the line across the flat end of the cone is above the surface of the mattress, the space passes the test. If the line across the flat end of the cone is at or below the top surface of the mattress, the space fails the test. The maintenance worker indicated that they had used the assembled cone and cylinder to perform the zone 3 test. The maintenance worker indicated that they had not been aware of the line across the flat end of the cone.

In summary, the severity of the issues identified was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issues identified was level 3 as they related to all residents' bed systems and six of the six residents reviewed. The home had a compliance history of 4 as there was ongoing non-compliance with O. Reg. 79/10, s. 15 (1):

- compliance order (CO) #001 was issued on December 21, 2017, with a compliance date of March 21, 2018. The CO was amended, as per request from the licensee, on March 13, 2018. The amendment was in relation to the compliance date, which was extended to April 6, 2018.

Consequently, a second CO pursuant to O. Reg. 79/10, s. 15 (1) will be issued to the licensee. (133)

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

Nov 30, 2018(A1)

## 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

## 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

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

## 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

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  10  day of September 2018 (A1)**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Amended by JESSICA LAPENSEE - (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 :** Ottawa