Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 1, 2018	2018_619550_0009	010358-18	Resident Quality Inspection

Licensee/Titulaire de permis

Taminagi Inc.
5 Loiselle Street CP Box 2132 Embrun ON K0A 1W1

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

Sarsfield Colonial Home
2861 Colonial Road P.O. Box 130 Sarsfield ON K0A 3E0

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

JOANNE HENRIE (550), AMANDA NIXON (148)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 28, 29, 30, 31, June 1, 2, 3, 4, 5, 6, 7, 8, 15, July 4 and 11, 2018.

During the course of the inspection, the inspector(s) spoke with the home's Administrator, the Operation Manager, the Director of Care (DOC), the Dietician/Nutrition Manager (RD/NM), the Activity Director, the RAI-MDS Coordinator, the Physician/Medical Director, several Registered Nurses (RN), several Registered Practical Nurses (RPN), several Personal Support Workers (PSW), a food service worker (FSW), the human resource/education/health and safety person (HR/Ed/H&S), laundry aides (LA), an office clerk, the president of the family council, a member of the resident council, several family members and several residents.

In addition, the inspectors reviewed resident health care records, the skin and wound program, resident and family council minutes. Inspectors observed resident care and services, staff and resident interaction, and meal services.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

14 WN(s)
9 VPC(s)
2 CO(s)
1 DR(s)
0 WAO(s)

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 71. (1)	CO #002	2018_617148_0002	148

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee specifically failed to ensure that the resident-staff communication and response system:
(c) allows calls to be cancelled only at the point of activation
(d) is available at each bath and shower location used by residents, and
(f) clearly indicates when activated where the signal is coming from

For the purpose of this report, the resident-staff communication and response system is also referred to as the call bell system.

During the initial tour of the home inspector #550 observed the following in the tub and shower rooms on all three resident floors:

1st floor tub and shower room:
Inspector #550 noted small black devices on the walls that looked similar to a door bell; one was located next to the shower area and one located next to the toilet. PSW #119 told the inspector this was to be used to alert staff that assistance was required. The inspector pushed the button on the device located next to the toilet and an alarm was activated. The annunciator indicated "alarm building front door, alarm spa room panic button 1st floor". The inspector pushed on that same button to cancel and the alarm did

not cancel. PSW #119 was not sure how to cancel this alarm, indicating to the inspector to try pushing on the button which inspector did again and this still did not cancel the alarm even after being pushed a few times. The PSW indicated that maybe it needed to be cancelled at the nursing desk and proceeded to go to the nursing station, where there was a console on the wall with a key pad. The PSW attempted to cancel the alarm by entering a code and this did not work. The PSW then asked the RAI coordinator who was nearby if they knew what the code to cancel the alarm from the tub room was. The RAI coordinator indicated they were not sure and tried a code which cancelled the alarm.

2nd floor tub and shower room:
Inspector #550 observed there was no call bell in the shower area of this tub room. The same black device from the first floor tub and shower room was on the wall next to the toilet and the inspector pushed on the button to activate the alarm. An alarm sounded and an annunciator indicated "alarm building front door, alarm", the inspector was not able to hear the rest of the message as the sound of the alarm was very loud. PSW #121 indicated to the inspector that it was the alarm for the door on the lower level and left to attend to the alarm. The inspector took the staircase to go to the lower level floor and noted at the main entrance a male staff member attempting to cancel the alarm at this door. As the inspector continued to the lower level, the alarm was cancelled. The inspector met PSW #121 in the hallway on the lower level and was told by the PSW that the alarm had been from the staff entrance door located at the end of the hallway. The annunciator was not providing the accurate location of where the alarm was coming from.

3rd floor tub and shower room:
Inspector #550 pushed on the black device on the wall next to the toilet. The alarm sounded and the annunciator indicated the same message as the 2nd floor tub and shower room. The inspector was not able to cancel the alarm at the point of activation, it had to be cancelled at the console which was located on the wall on the other side of the hallway next to a desk.

The inspector toured the tub and shower room on each floor accompanied by the Administrator #122. During this subsequent observation, the call bells in the tub and shower rooms could not be cancelled at the point of activation. They could only be cancelled by keying a code on the console located on the wall across the hall from the tub and shower rooms. The Administrator noted that the message from the annunciator was not providing clear directions as to where the alarm was coming from and indicated they would call the repair company. The Administrator also noted that there was no call

bell in the shower area of the second floor tub and shower room.

As evidenced, the call bells in the tub and shower rooms on all three floors could not be canceled at the point of activation. There was no call bell in the shower area of the tub and shower room on the 2nd floor and it did not clearly indicate where the signal is coming from when activated. [s. 17. (1)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, residents were assessed and the bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, steps are taken to prevent resident entrapment, taking into consideration all potential zone of entrapment; and other safety issues related to the use of bed rails are addressed, including height and latch reliability.

On Feb 6, 2018, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of a Follow Up Inspection #2018_617148_0002. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been

complied with by May 11, 2018.

The licensee was ordered, in part, to take the following action:
1. Re-evaluate all bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). In consideration of rotating assist rails, all intermediate positions are to be evaluated;
2. Establish and implement a process for ensuring that any bed system failures are addressed immediately. Document corrective actions taken;
3. Maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident. Ensure that a re-evaluation of a bed systems is completed as required;
4. Establish and implement a process for ensuring that all residents with bed rails are assessed in accordance with the 2003 FDA clinical guidance document;
5. The resident assessment along with the names of the team members who participate in the assessment and decision making process, including the risk benefit assessments, is to be documented;
6. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternatives to bed rail use; and
7. Develop and implement a documented ongoing auditing process to ensure that all requirements of this compliance order are satisfied.

Residents #001, #003, #004, #007, #012, #014, #016, #025 and #026 were initially observed on a specified date and over the remaining course of the inspection to have bed rails in use. The following is a summary of the health care record review, observations and staff interviews related to the use of bed rails:

Resident #001 – was observed to have two rotating assist rails, while in bed, in the guard position. Staff reported that the resident uses the bed rails for bed mobility. The resident was unable to describe the use of the rail. The plan of care indicated the resident use the rails to assist in repositioning while in bed.

Resident #003- has had two identified falls from bed in an identified period of time, and was observed to have one rotating assist rail in the assist position. Staff reported that the resident used the bed rail to reposition while in bed. The resident was unable to describe the use of the rail. The plan of care, under the item of falls, indicated that the resident

met the requirements for the safe use of assisting rails and to have one side rail up as it related to the risk of falls and for repositioning in bed.

Resident #004 – had an air mattress and was observed with two rotating assist rails, one in the guard and one in the assist position. Staff reported that the resident was not able to use the bed rails and that both rails were applied at the family's request. Staff reported that when the resident was is in bed both bed rails are placed in the guard position. The plan of care indicated that the resident did not meet the requirements for the safe use of assisting rails.

Resident #007 - was observed with one rotating assist rail in the assist position. Staff reported that the resident used the rail in the assist position to sit up in bed from a supine position. The resident expressed a desire to have the rail but was not able to indicate the use of the rail. The plan of care indicates that the resident met the requirements for safe use of assisting rails. The plan of care indicated the use of one rail for bed mobility and for the resident's emotional comfort and security.

Resident #012 –was observed with one rotating assist rail, while in bed, in the assist position. Day staff reported that the resident used the rail in the assist position to assist in transfers in and out of bed. Evening staff reported that the resident will use the rail in both the assist and guard position; the resident will use the rail in the assist position for repositioning and the rail in the guard position for bed mobility when in bed. The resident was unable to describe the use of the rail. The plan of care, under the item of falls, indicated that the resident met the requirements for the safe use of assisting rails and use of bed rails for repositioning in bed.

Resident #014 – was observed with one rotating assist rail in the assist position. Staff reported that the resident will use the rail in both the assist and guard position; the resident will use the rail in the assist position for repositioning and the rail in the guard position for bed mobility when in bed. The resident was unable to describe the use of the rail. The plan of care indicated that one bed rail is used to assist with repositioning and for emotional comfort and security.

Resident #016 – was observed to have one rotating assist rail in the assist position. Staff reported that the rail is placed in the guard position when the resident is in bed to assist with repositioning. The resident was unable to describe the use of the rail. The plan of care under items of transfer, bed mobility and falls, indicated the use of one rail. The plan of care under items of sleep and restraints indicated the use of two rails for safety.

Resident #025 – had a history of falls and was observed in bed with one assist rail in the assist position. Staff reported the resident used the rail to assist with transfers out of the bed. The resident was unable to describe the use of the rail. The plan of care, under the item of falls, indicated that the resident met the requirements for safe use of the rail for transfers and bed mobility.

Resident #026 – had a history of falls, and the resident's bed system was observed to have one rotating assist rail in the guard position. Staff reported the resident used the rails for repositioning. The resident was unable to describe the use of the rail. The plan of care, under the item of falls, indicated that the resident met the requirements for the safe use of assisting rails and to have one side rail up as it related to the risk of falls.

The Director of Care and RAI Coordinator were identified as the two leads responsible for the resident assessment required by O.Reg 79/10, s.15 (1) and the Compliance Order of February 6, 2018.

Inspector #148 spoke with the RAI Coordinator on June 5, 2018, who identified two newly developed tools for the resident assessment of bed rails. The first tool was titled, Assisting Rail and Bed Entrapment Risk Assessment (Risk Assessment) and the second titled, 7 Day Bed Safety Assessment/Bed Entrapment Record. The RAI Coordinator said that the nursing staff complete the 7 day observation record, after which, the RAI Coordinator will complete the Risk Assessment document. When all data is collected the RAI Coordinator and DOC would discuss the findings and decide if the resident can use the bed rails. The Inspector requested copies of the completed resident assessments for the sampled residents, as identified above. The RAI coordinator said that no assessments had been completed for residents previously residing in the home and that assessments had only been initiated for newly admitted residents. The RAI Coordinator identified that a specified resident was the first resident to have an assessment initiated. It was described that the 7 day observation period had past and the Risk Assessment form had been completed but that there had been no discussion with the DOC about the data collected. In addition to this, the RAI Coordinator expressed that the assessment tools developed were not clear and that the RAI Coordinator had questions for the DOC regarding the tools implementation. In discussion of the tools, the RAI Coordinator was not able to identify where the benefits were reviewed or where a risk benefit assessment would be documented.

The Inspector discussed the resident assessment of newly admitted residents with the

RAI Coordinator. The RAI Coordinator described that upon admission a discussion would be had with the family and/or resident along with a review of the record to assess if the resident could use bed rails. The RAI Coordinator described that bed rails may be applied to a newly admitted resident's bed system prior to the completion of the resident assessment.

The Inspector discussed the plan of care statements noted above, whereby the resident are identified as meeting the requirements for the safe use of bed rails. The RAI Coordinator said that this phrasing is taken from the previous resident assessment tool titled Assessment of Assisting Rail. This assessment was identified in the February 6, 2018 inspection report to not be compliant with section 15(1)(a) of O. Regulation 79/10. The RAI Coordinator reported that the Assessment of Assisting Rail tool has been used to assess new admissions. The Inspector reviewed the health care records of two identified residents, who were newly admitted to the home. In the record of one resident, the Assessment of Assisting Rail tool was completed on a specified date, indicating the use of one assist rail. In the record of the other resident, the Assessment of Assisting Rail tool was completed on a specified date, indicating the use of one assist rail.

Inspector #148 spoke with the home's Director of Care regarding the resident assessment for use of bed rails. The DOC confirmed that the Assisting Rail and Bed Entrapment Risk Assessment (Risk Assessment) and the 7 Day Bed Safety Assessment/Bed Entrapment Record were the tools available for the resident assessment related to bed rails. The DOC further reported that it was the DOC and the RAI Coordinator that composed the interdisciplinary team for the resident assessment. The DOC described that it was the DOC that developed the tools to be used in the resident assessment; the Professional Advisory Committee and RAI Coordinator were provided with an opportunity for input. In review of the tools identified, the tools did not offer an area for the documented risk benefit assessment. When discussed, the DOC was unable to describe the risk benefit assessment or where the risk benefit assessment would be documented. In discussion of the resident assessment process in place, the DOC said that she was unaware of how many resident assessments had been completed but noted that the tools had been implemented about a month ago. The DOC described that the intent was to have the resident assessments completed for all existing residents in the home over the next quarter in conjunction with the Minimum Data Set (MDS) quarterly assessments; newly admitted residents would have a resident assessment on admission.

It was determined that the licensee had not established and implemented a process for

the resident assessment in accordance with prevailing practices. At the time of the inspection no resident in the home with bed rails in use, had a completed resident assessment nor had a risk benefit assessment taken place. Further to this, it was demonstrated that the home continued to apply bed rails for newly admitted residents without a completed resident assessment and had intended for resident assessments, of those currently residing in the home, to be done over the next three months while bed rails continued to be in use. In addition, the plans of care do not provide for clear direction to staff on the use of the rotating assist rail or the position of the rotating assist rail when in use.

On June 6, 2018, inspector #550 interviewed the Operation Manager #132 in the presence of the Administrator #122 regarding the bed entrapment evaluation. The Operation Manager #132 informed the inspector that they had conducted the evaluation of the bed system with the assistance of maintenance person #133 in the home. They indicated having referenced to the Health Canada guidance document "Adult Hospital Beds: Patient entrapment Hazards, Side Rail Latching Reliability and Other Hazards" and used a cone and cylinder tool to conduct the evaluations. They provided the inspector with a document titled Facility Entrapment Inspection sheet, indicating this document was used to document the evaluation of the bed systems. The Operation Manager #132 explained to the inspector the legend for the codes used on the entrapment inspection sheet:
"L" indicated one full bedrail on each side of the bed
"SM" indicated one quarter rail in the middle part of the bed
"Med" or "M" indicated one small rail at the head of the bed
"D" indicated one small rail at the head of the bed on each side
"R" indicated removed
"I" indicated installed
"P" indicated pass and "F" indicated failed.

The inspector reviewed the facility entrapment inspection spreadsheet with the Operation Manager #132. The Operation Manager indicated that the home did not have any beds equipped with two half rails on one side of the bed therefore zone 5 was not applicable. During a tour of all the beds in the home, the inspector had observed that the only type of rails used in the home were rotating assist rails and one resident had one half bed rail. The inspector noted there was no documentation on the facility entrapment inspection sheets indicating rotary assist rails were used in the home and that they were evaluated in the three different positions. Rotating assist rails have three position; when in the assist position, the rail is in the vertical position at the head of the bed, when in the guard

position, the rail is in the horizontal position in the middle part of the bed and when in the intermediate position, the rail is in a diagonal position (between the assist and the guard position) in the middle part of the bed. The Program Manager #132 told the inspector that they were not aware that the rotating assist rails had three different positions therefore they were only evaluated in the position they were in at the time of the evaluation.

It was documented on the inspection spreadsheet that the bed system evaluation was conducted on January 9 and 17 and March 12 and 13, 2018. The following was noted documented on this spreadsheet sheet and confirmed by the Operation Manager:

At the time of the bed system evaluation:

Bed #02 was not evaluated, it was documented on the inspection sheet that there were no bed rails on the bed at the time the evaluation was conducted. It was also documented on the inspection sheet that a small rail was installed after. Upon observation on June 5, 2018, the inspector noted that bed #02 was equipped with one rotating assist rail in the assist position at the head of the bed on the right side. The mattress was too long, it did not fit into the mattress keeper and it exceeded the deck frame of the bed by approximately two inches on the left side as it appeared that the mattress had slid off the frame.

Bed #21 was equipped with a full bed rail on each side of the bed (L), it had passed all zones and both rails were removed after the evaluation. Upon observation on June 5, 2018, the inspector noted that bed #21 was now equipped with one rotating assist rail in the guard position in the middle part of the bed on the right side.

Bed #23, was equipped with a quarter rail in the middle part of the bed, it had passed all zones and after the bed system evaluation, the quarter rail was removed. Upon observation on June 5, 2018, the inspector noted that bed #23 was now equipped with one rotating assist rail in the guard position in the middle part of the bed on each side.

Bed #27 was equipped with one quarter rail in the middle of the bed (SM) and had passed all zones. Upon observation on June 5, 2018, the inspector observed bed #27 was equipped with a rotating assist rail in the guard position in the middle part of the bed on each side and had an air pressure relief mattress. The Director of Care #116 told the inspector that the air pressure relief mattress was installed on this bed on a specified date, after the bed system evaluation was made.

Bed #31 was equipped with a full bed rail on each side of the bed (L), it had failed zone 2 and the mattress needed to be replaced. Both bed rails were removed after the evaluation. Upon observation on June 15, 2018, the inspector observed that bed #31 was equipped with a rotating assist rail in the middle part of the bed on each side.

Bed #34 was equipped with 1 full rail on each side of the bed (L), had passed all zones and that after this evaluation, both rails were removed. Upon observation on June 5, 2018, the inspector noted that bed #34 was equipped with one rotating assist rail in the guard position in the middle part of the bed on the right side and that the mattress did not fit into the mattress keeper as it was too long.

Bed #41 was equipped with one small rail on each side at the head of the bed (D), had passed all zones and after the evaluation of this bed system, both bed rails had been removed. Upon observation on June 5, 2018, the inspector noted that bed #41 was equipped with one rotating assist rail in the assist position at the head of the bed on the right side. The inspector attempted to move the rail to the guard position but the rail would not go all the way down, it stopped before it could reach the guard position.

Bed #43 was equipped with a full bed rail on each side of the bed (L), it had failed zone 2, 3 and 4. The mattress was changed and both bed rails were removed after the evaluation. Upon observation on June 5, 2018, the inspector observed bed #43 was equipped with one rotating assist rail in the assist position at the head of the bed on the right side. When the inspector verified the rotating assist rail, it was loose.
Two specified residents were newly admitted and were observed to have bed rails in use. At the time of the inspection, no bed system evaluation had been completed for the newly admitted residents as the tool required to complete the evaluation was not accessible to the home as described below. The home had intended to continue the use of the bed rails without a bed evaluation was completed.

The Operation Manager indicated to the inspector that beds #02, #21, #23, #27, #34, #41, and #43 were not re-evaluated when modifications were made to those bed systems as they were not made aware of the changes. They had not been made aware that the rotating assist rail on bed #043 was defective.
The Operation Manager #132 further indicated that the home does not own the tool to evaluate the bed systems, they had borrowed it from another home and had returned it after they had completed the initial bed system evaluations on March 13, 2018. Because of this, no bed system was re-evaluated when changes were made or when a new bed

system was created. As per a discussion with the Program Manager #132 and the HR/ED/H&S #108, the mattresses that required to be replaced were not replaced and there was no documentation to indicate when the new rails were installed.

Inspector #550 noted that the bed system documented on the "evaluation entrapment inspection sheet" at the time of the evaluation differed from what was observed on June 5 and 15, 2018 by the inspector. The Operation Manager #132 told the inspector that some of the beds and bed system have changed since the evaluation was conducted and that they were not made aware of the changes. They do not document the changes or have a bed system inventory that is kept up to date.

Room 102 had bed #04, now has bed #41 and the bed system was modified.
Room 204-2 had bed #06, now had bed #34 and the bed system was modified.
Room 101-1 had bed #24, now had bed #26 and the bed system was modified.
Room 105-1 had bed #31, now had bed #20 and the bed system was modified.
Room 300-1 had bed #20, now had bed #31 and the bed system was modified.

It was unknown if the above bed systems were still assigned to the same residents they were assigned to when the evaluation was conducted. [s. 15. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

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

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 there is a written plan of care for each resident that sets out, (a) the planned care for the resident.

A review of resident #001's health care records and interviews with staff indicated this resident currently had a specified skin integrity issue to a specified body area.

Inspector reviewed the resident's written plan of care including physician orders and eTars and was not able to find any documentation indicating what the treatment was for this resident's skin integrity issue.

RN #106 who is the full-time day RN in the home indicated to the inspector that every resident with specific skin integrity issue is treated with a specified treatment plan. The RN indicated this treatment was not written in the resident's plan of care because the home is a small home and everybody knows what the treatment is for this specific skin integrity issue.

As evidenced, the planed care for resident #001's skin integrity issue was not included in the written plan of care. [s. 6. (1) (a)]

2. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Inspector #550 reviewed resident #001's health care records and noted documented on the Minimum Data Set (MDS) assessment dated on a specified date, section M indicated that resident #001 had a two identified skin integrity issues to specified body parts. A progress note by RPN #100 indicated the resident had a new skin integrity issue to a specific body part which was later identified as a specific skin integrity issue by RN #128. Another progress two days later identified the resident had skin integrity issue to two different body parts. Twenty seven days later, a progress note from RN #106 indicated the resident had a specified skin integrity issue to a different identified body part. During an interview, RN #127 told the inspector this resident had one specific skin integrity issue to a specified body part. Documentation in the progress notes by RN #129 the day prior to the interview with RN #127, described the resident's skin integrity issue to be worse than what was indicated by RN #127. The following day, RN #106 provided the inspector with a specified form dated that same day. It was documented on this form that resident #001 had three different skin integrity issue to a specific body part and another skin issue to a different body part. The RN later informed the inspector that they had made an error and the resident had a skin integrity issue on one specified body part and another specified skin issue on another specified body part.

Inspector #550 reviewed this resident's health care records and noted documented in a progress note by RPN #100 that resident #001 had a new skin integrity issue to a specific body part, which was later identified as a different skin integrity issue by RN #128. The Registered Dietician (RD) #107 assessed resident #001 on a specified date and documented in the progress notes and in the resident's care plan that the resident had a history of a specific type of skin integrity issues, and that they presently had a specified skin issue to a specified body area due to a specific condition. There was no indication of skin integrity issue identified by RN #106.

The RD told the inspector they were not aware that resident #001 had developed a specific skin integrity issue to a specified body area. When a resident develops a skin issue, they fill out a specified form and then forward it to the RD to inform of the new skin issue. The RD added that they never received this form for this resident therefore had not been made aware of the new skin issue.

During an interview, the home's Physician/Medical Director #120 indicated to the inspector they had not been made aware by anyone that resident #001's skin integrity issue was not healing and that they had developed more skin integrity issues. [s. 6. (4) (a)]

3. Inspector #550 reviewed the the documentation in resident #010's healthcare records. It was documented on the MDS assessment that this resident had two specified skin integrity issues. The inspector was not able to find any documentation to identify the location of the first skin integrity issues. During an interview, the RAI-MDS coordinator #114 indicated that they do the coding in MDS as per the skin assessment (MDS section M) form provided to them by the registered nursing staff. The inspector and the RAI-MDS coordinator reviewed the skin assessment (MDS section M) form for this resident, for a specified assessment period date which was signed by RN #130. Under a specific skin issue, it was indicated none and a circled handwritten note identified another specific skin integrity issue. The RAI-MDS identified themselves as adding the handwritten note. There was no indication of the first specified skin issue on this document. In the RAP summary, the RAI coordinator #114 had documented the second skin integrity issue to a specified body part. The RAI-MDS coordinator told the inspector they would have coded the first specified skin issue on the MDS assessment if the resident had a specified symptom but they were unable to provide documentation indicating resident #010 had this symptom to any location on the body. The RAI-MDS coordinator stated the resident's skin integrity issue to a specified body part should have been coded as per

their discussion with staff. [s. 6. (4) (a)]

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

During meal observations, Inspector #148 identified three residents, residents #017, #019 and #024, who were care planned to receive a weight reducing therapeutic diet. A definition of the weight reducing diet is available to staff on the dietary kardex. The definition includes that residents on the weight reducing diet are to be provided with ½ portion starch and 1.5 portions of vegetables. This definition was confirmed with the RD/NM.

At the breakfast meal service on June 4, 2018, FSW #112 who was serving the breakfast meal, reported that there was no difference between the regular and weight reducing diet at breakfast. At the lunch meal service on the same day, Cook #113 who was serving the lunch meal, reported that residents on the weight reducing diet would receive half portions of each food item. During the meal observations at both meal services, the identified residents were served the regular portions size of food.

Resident #017, #019 and #024 were not provided with the weight reducing diet as set out by the plan of care. [s. 6. (7)]

5. The licensee specifically failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when, (b) the resident's care needs change or care set out in the plan is no longer necessary.

A review of the progress notes for resident #010 indicated that the Physician/Medical Director #120 diagnosed a specific skin issue to a specific body part on resident #010. This skin issue was previously diagnosed as a different type of skin issue.

Inspector #550 reviewed resident #010's actual written plan of care and noted that the skin integrity issue documented with interventions was not the actual skin integrity issue. It was the previous diagnosis of the skin issue. There was no documentation of the actual skin integrity issue to the specific body part.

During an interview, RN #106 indicated to the inspector that resident #010 had previously been diagnosed with a specific skin issue but that the diagnosis had recently been

changed to a different skin integrity issue by the physician. The DOC indicated that this resident's written plan of care was not revised when the physician changed the diagnosis to a different skin integrity issue to reflect this new diagnosis [s. 6. (10) (b)]

6. A review of the documentation in resident #018's health care record indicated that the resident had a specific type of skin integrity issue to a specified body area and that it had worsened during the following week and developed into another specific type of skin integrity issue. RPN #104 indicated to the inspector that resident #018 currently had a specific type of skin integrity issue to a specific body part and required a specified treatment.

Inspector #550 reviewed resident #018's current written plan of care and noted that the type of skin integrity issue identified was the initial type of skin issue and not the current type of skin issue with a different treatment plan. The plan of care did not reflect the changes in the progression of the skin integrity issue and the change in the treatment plan.

During an interview, the DOC indicated to the inspector that the written plan of care for this resident was not revised when the skin integrity issue developed into another type of skin issue and that it should reflect the current treatment. [s. 6. (10) (b)]

7. The licensee has failed to ensure that if the resident is being reassessed and the plan of care is being revised because care set out in the plan of care has not been effective, different approaches have been considered in the revision of the plan of care.

Resident #001 currently had a specific skin integrity issue identified to a specified body area. A review of the resident's health care records and interviews with staff and the Physician/Medical Director #120, indicated that this resident has had recurring skin integrity issues for a specified period of time due to a specific behaviour by the resident. A specified treatment plan was identified. During an interview, RN #106 told inspector #550 that an Enterostomal Nurse (ET nurse) was not consulted when resident #001's skin integrity issues kept recurring after having been healed. RN #106 said that their medical supplies provider offers the services of an ET nurse to assess residents with pressure ulcers.

The documentation in resident #018's health care records, interviews with staff and the physician/medical director indicated that the resident has a history of a recurring skin integrity issue to a specified body area.

During an observation of resident #018, the inspector observed the resident did not have a pressure relieving device while in a specific position.

Although this resident has a history of a recurring skin integrity issue to a specified body area, the resident was not referred to the ET nurse as they usually refer residents with specific types of skin issues.

During an interview, the DOC indicated to the inspector that a referral to the OT was not completed for this resident as in the past the resident's SDM had refused that the OT assess the resident for other issues. This SDM was not contacted regarding the resident's need for a pressure relieving device. During an interview, the Administrator #122 told the inspector that they would contact the resident's SDM themselves regarding the need of a pressure relieving device for this resident.

As evidenced the licensee did not ensure that different approaches were considered in the revision of resident #001 and #018's plan of care. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written plan of care for each resident sets out the planned care for the resident, staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other, the care set out in the plan of care was provided to the resident as specified in the plan, the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary and when a resident is reassessed and the plan of care is reviewed and revised because the 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, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee specifically failed to ensure that the following interdisciplinary program was implemented in the home:
A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

The home's skin and wound program titled Skin and Wound Care Program Policies and Procedures was provided by the DOC and reviewed by Inspector #550. The program described responsibilities/procedures for the Registered Dietician, the Director of Care/designate, the Registered Staff and the Physician. It also outlined specific directives for the management of the different types of skin integrity issues.

As documented throughout this report, resident #001, #010 and #018 were identified with specific types of skin integrity issues.

During an interview, the physician/medical director #120 indicated to the inspector that the home uses an identified treatment for two specified skin integrity issues and that they will consult with the physician when the treatment is not effective. The physician/medical director #120 was not aware that the home's skin and wound program required them to complete medical orders for the treatment of the wounds and that they have to document the outcome of the treatment. The registered nursing staff have not informed them when the resident's skin integrity issue did not improve with 3-4 weeks of initiating a treatment.

During an interview, the DOC told the inspector that they are in charge of the skin and wound program and because of all the other duties that are required of them, the DOC did not have time to ensure that the skin and wound program was implemented in the home. They did not ensure weekly follow-up with RN/RPN were done accordingly as per policy and follow the healing process of all skin integrity issues on a regular basis. The DOC reviewed the skin and wound program with the inspector and indicated the staff have not implemented the skin and wound program by not following the established policies.

As evidenced in this report in WN #3 and #6, interviews with the physician/medical director, registered nursing staff and the DOC, the licensee's Skin and Wound Care Program Policies and Procedures was not implemented in the home. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the skin and wound program is implemented in the home, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are:
• equipped with locks to restrict unsupervised access to those areas by residents, and
• locked when they are not being supervised by staff

During the initial tour of the home on May 28, 2018, inspector #550 observed the following doors to be unlocked:

Lower level:
The pantry/dry storage room door was open and unlocked. There were no staff member inside and the room is not visible from inside the kitchen. Food Service Worker (FSW) #112 came to close the door and returned to the kitchen. The inspector verified the door again and it was still unlocked. The inspector went to see FSW #112 in the kitchen and they told the inspector that the door to the Pantry/Dry storage room was always unlocked. They then proceeded to lock the door.

The maintenance and cleaning room door next to the pantry/dry storage was unlocked and there was a sign on the door indicating "Close door – Keep locked at all times.

Health and Safety – chemicals inside room". There was no staff inside this room and the inspector observed there were tools, equipment, cleaning products, electric panels and a boiler in the room.

1st floor:
The door for the linen closet next to room 107 was unlocked.
The door to the staff washroom next to the activity storage was unlocked and ajar.

2nd floor:
The door to the visitor's washroom next to medication room was unlocked.

3rd floor:
The door to the activity department storage next to the Director of Activity's office was not locked. There was a sign indicating "Please keep door locked at all times". Inside the storage room there were activity supplies, 3 bottles of "Off" bug spray and a breaker panel. This door was left open again on June 1st, 2018. The inspector observed the Activity Director #101 coming and going into this storage room a few times during that day and always left the door ajar.

There were no staff member supervising those doors during the inspector's observations.

During an interview, the Administrator #122 told the inspector that all the areas mentioned above were non-residential areas and they were to be kept closed and locked at all times when they were not supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are locked when they are not being supervised by staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

Resident #001 was identified high risk for skin integrity issues as per a specified assessment.

Inspector #550 reviewed resident #001's health care records and noted documented on the Minimum Data Set (MDS) assessment dated on a specified date, section M indicated that resident #001 had a two identified skin integrity issues to specified body parts. A progress note by RPN #100 indicated the resident had a new skin integrity issue to a specific body part which was later identified as a specific skin integrity issue by RN #128. Another progress two days later identified the resident had skin integrity issue to two different body parts.

During an interview, RN #106 indicated that the skin assessments by the registered nursing staff are documented in the progress notes in the Medicare system. They don't use a specific tool to assess the skin integrity issues, they document their observations in Medicare

The Director of Care indicated to the inspector that when a resident develops a new skin integrity issue, the registered staff is to assess the skin integrity issue using a specified assessment tool and keep this assessment in the resident's health care records.

As evidenced, resident #001 was not assessed by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment when this resident developed a new skin integrity issue to a specific body part on a specified date and a new skin integrity issue to another specified body part. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required.

A review of the resident's health care records and documentation on the Minimum Data Set (MDS) assessment, section M, indicated that resident #010 had a skin integrity issue to a specified body part.

RN #106 told the inspector resident #010 had this skin integrity issue for a long time and described to the inspector the specified treatment for this type of skin integrity issue. The registered nursing staff are to document in the progress notes each time they do a treatment to a resident.

The progress notes were reviewed by the inspector and it was observed that there was no documentation indicating that a treatment was provided to the resident's specified skin integrity issue on one hundred and two (102) days out of one hundred and nine (109) days observed.

On a specific date, it was documented in the progress notes a PSW reported that the resident complained of pain to a specified body part, that the resident had a skin integrity issue to this same body part and to continue to monitor for signs of infection. Two days

later, it was documented the resident was complaining of pain to this same specified body part. There was no documentation of interventions to reduce or relieve the pain.

The inspector reviewed the eMARS/eTARS for resident #010 and noted there was no documentation regarding a treatment for the skin integrity issue for four consecutive months. There was no documentation indicating that the resident was administered a pain medication although one was prescribed on an as needed basis.

During an interview, the DOC indicated to the inspector that registered nursing staff are required to document in the progress notes each time a treatment is performed to a resident and if there was no documentation, it was because it was not done. The administration of pain medication is documented in the resident's eMARS by the registered nursing staff when it is administered.

As evidenced, resident #010 who was identified with a skin integrity issue did not receive interventions to reduce or relieve pain and to promote healing, as required. [s. 50. (2) (b) (ii)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Inspector #550 reviewed resident #001's health care records and noted documented on the Minimum Data Set (MDS) assessment dated on a specified date, section M indicated that resident #001 had a specified skin integrity issue to a body part and another specified skin issue to another body part. A progress note by RPN #100 indicated the resident had a new skin integrity issue to a specific body part which was later identified as a specific type of skin integrity issue by RN #128. Another progress two days later identified the resident had skin integrity issue to two different body parts. Documentation in the progress notes by RN #129 on a specified date indicated the resident's skin integrity issue to a specified body part was not improving and nine days later, RN #106 told the inspector the resident currently had specified type of skin integrity issue to a specified body part.

During an interview with RN #106 indicated that residents who have skin integrity issues are reassessed at least weekly by the registered staff and this is documented in the progress notes in the Medicare system. RPN #104 indicated to the inspector that the registered staff reassess the resident's skin integrity issues twice per week on the

resident's bath day and they document in the progress notes a description of the skin integrity issue.

Th inspector reviewed the progress notes for resident #001 in Medecare for a period of four consecutive months. There was no documentation indicating that a reassessment of this resident's specific skin integrity issue was completed for five (5) out of the sixteen (16) weeks reviewed.

As evidenced, resident #001's skin integrity issues were not reassessed at least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

4. A review of the resident's health care records and documentation on the Minimum Data Set (MDS) assessment, section M, indicated that resident #010 had a skin integrity issue to a specified body part.

During an interview, RN #106 indicated that resident #010 had this skin integrity issue for a long time and all residents who have skin integrity issues are reassessed at least weekly by the registered nursing staff and the assessment is documented in the progress notes in the Medicare system. RPN #104 indicated to the inspector that the registered staff reassess the residents' skin integrity issues twice per week on the resident's bath day and they document in the progress notes a description of the skin integrity issue.

This inspector reviewed the progress notes for resident #010 in the home's electronic documentation system for a specified period of time. There was no documentation indicating that a reassessment of this resident's skin integrity issue for ten (10) out of the fifteen (15) weeks reviewed.

As evidenced, resident #010's skin integrity issue was not reassessed at least weekly by a member of the registered staff. [s. 50. (2) (b) (iv)]

6. Documentation on the MDS assessment for a specified date for resident #018 was reviewed by inspector #550. It was documented that this resident had a skin integrity issue. A progress note on a specified date indicated a different type of skin integrity issue to a specified body part and this was confirmed by an interview with RN #104. RN #106 and physician/medical director #120 indicated to the inspector during an interview, this resident's skin integrity issue was recurring to the same body part.

Inspector #550 reviewed the progress notes for resident #018 for a specified period of

fourteen (14) weeks. The inspector was not able to find any documentation to indicate that an assessment of the resident's skin integrity issue had been conducted, except for a note indicating the presence of the skin integrity issue on four specified days.

RPN #104 indicated to the inspector that the registered nursing staff reassess the resident's skin integrity issues twice per week on the resident's bath and they document in the progress notes a description of the skin integrity issue. RN #106 indicated that the registered nursing staff document the reassessment of the skin integrity issues in the resident's progress notes at least weekly.

As evidenced, there was no documentation indicating that resident #018's wound was reassessed weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

7. The licensee has failed to ensure that equipment, supplies, devices and positioning aids are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing.

Resident #001 was identified at being high risk for skin integrity issues as per a specified assessment completed on a specified date.

The resident was observed on different days lying in bed on a regular type mattress.

Documentation in the resident's health care records, interviews with staff and the Physician/Medical Director #120 indicated that the resident has had skin integrity issues to a specific body part for a long time and that they are recurring; they heal then return. This resident has a specific behavior which is contributing to the skin integrity issue.

Interview with RN #106 indicated that resident #001 currently had a specific type of skin integrity issue to a specific body part, another specific skin integrity issue to another body part and different skin issue to another body area. The RN and DOC indicated this resident would benefit from a pressure relieving air mattress but they only have one or two of them in the home and they are currently being used by other residents. [s. 50. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment, receive immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, and that equipment, supplies, devices and positioning aids are readily available as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (1) Every licensee of a long-term care home shall ensure that, at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home. 2007, c. 8, s. 85. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home.

Inspector #148 spoke with the identified President of the Residents' Council, resident #013, who had been living in the home for many years, did not recall having participated in a satisfaction survey in the past. The Inspector spoke with the liaison for the Residents' Council, the Activity Director staff member #101. The Activity Director reported awareness of a satisfaction survey having been sent out to family members earlier in the year but was not aware of a satisfaction survey for residents.

Staff member #108 was identified as having knowledge related to the development and distribution of the satisfaction survey. In discussion, staff member #108 and the home's Administrator #122, reported that the most recent satisfaction survey was sent out to the substitute decision makers of residents in January 2018 by the office clerk staff member #111. Staff member #108 described the intention of the survey was for families to complete them with residents, as applicable. It was reported that no surveys were distributed to residents.

The licensee failed to ensure that at least once in every year, a survey of residents is taken to measure their satisfaction with the home and the care, services, programs and good provided by the home. [s. 85. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that at least once in every year, a survey is taken of the residents and their families to measure their satisfaction with the home and the care, services, programs and goods provided at the home, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair (Excluding the residents' personal aids or equipment).

During a tour of the 2nd and 3rd floor tub and shower room accompanied by Administrator #122, the inspector showed the Administrator there was no call bell in the shower area in the second floor tub and shower room. The Administrator indicated there used to be a black device like the one next to the toilet but it must have fallen off the wall at some point and they were not informed by anyone to replace it. Inspector #550 activated the call bell located on the wall next to the shower area in the 3rd floor tub and shower area and the call bell did not activate. The Administrator proceeded to activate the same call bell to no avail and then removed the cover from the device and told the inspector the batteries must have expired.

The Administrator indicated to the inspector that there are no procedures developed or in place to ensure that these devices are in place and functional. The PSWs are to inform them when the devices are missing or not working so they can repair or replace them but they were not informed of these deficiencies by anyone. [s. 90. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures were developed and implemented to ensure that all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
5. The person who applied the device and the time of application. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
6. All assessment, reassessment and monitoring, including the resident's response. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
8. The removal or discontinuance of the device, including time of removal or discontinuance and the post-restraining care. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff apply the physical device in accordance with any manufacturer's instructions.

Inspector #148 observed residents #021 and #022 to each have a lap belt in applied while seated in a wheelchair. Observations, health care record review and staff interviews confirmed the use of the lap belts as physical restraints. During observations on May 29, 30 and 31, 2018 the application of the belts were noted to be loose and could be pulled out from the resident's body several inches.

On May 29, 2018, the Inspector brought the loose lap belt of resident #021 to the attention of RPN #100 who described the belt as applied correctly. On May 30, PSW #102 identified the belt as loose but qualified that that resident continues to pull it loose and the belt does not stay fitted to the resident's body. On the same date, Activity Director #101, was identified as the lead for device use in the home. Upon review of the lap belt for resident #021, staff member #101 attempted to re-loop the strap of the belt to better manage the resident's ability to pull the belt loose. During observations of the resident later in the day on May 30 and in observations on May 31, 2018, it was noted that the belt was fitted to the resident's body, without excess slack. It was reported to the Inspector, by staff member #101, that resident #021 was seen by Motion Specialties on the afternoon of May 30, who applied a new lock clip to one side of the lap belt strap to prohibit the belt from loosening. Staff member #101described that resident #021 has had the lap belt applied since admission, whereby issues related to the fit of the belt have been identified, however, staff #101 could not demonstrate what actions had been taken to ensure the lap belt for resident #021 was applied correctly. Staff member #101 reported no access to manufacturer's instructions for the belt of resident #021, however described that the belt should be applied snug to the resident's body with only a hand width between the belt and body.

On May 31, 2018 the Inspector brought the loose lap belt of resident #022 to the attention of staff member #101. Staff member #101 provided adjustment to the belt and instructed PSW staff present of the need to ensure that the application of the belt is correct, including that the belt is to be snug to the resident's body. The Inspector observed the lap belt after the adjustment to be fitted to the resident's body without excess slack. The user instructions were located by staff member #101 and described that the lap belt must be worn tightly fitted across the lower pelvis or thighs at all times. [s. 110. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff apply the physical device in accordance with any manufacturer's instructions, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

As part of the process of the RQI (Resident Quality Inspection), inspector #550 reviewed the medication incidents for three consecutive months in 2018. There were three reported medication incidents documented as follows:

It was documented on medication incident report that resident #016 was not administered a specified medication at a specified time the day before; it was found still in its original packaging in a specified area in the medication card.

It was documented on a medication incident report that on a specified date three days earlier, resident #027 was prescribed a medication at a specified strength, to be administered three times daily for a specified period of time. On the same day, the physician told RN #125 via a telephone order to change the first medication to another medication at the same dosage. The physician did not specify the frequency for administration and the RN did not clarify this with the physician. Resident #027 received the correct medication at the correct strength but at the wrong frequency for three days until the error was discovered by RN #125 on the fourth day and called the physician. The new medication should have been administered two times per day and it was administered three times. The physician then provided a new order for the same medication.

It was documented on medication incident report dated January 2, 2018, that resident #028 was prescribed a specified medication at a specific dosage with orders to administer one tablet at bedtime. While signing the administration of the medication in the eMars, RPN #126 noted that they had administered two tablets of the medication instead of one tablet as per the physician's order.

The DOC #116 indicated to inspector #550 that resident #016, #027 and #028 were not administered their medication in accordance with the physician's directions. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident and every adverse drug reaction is:
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and
(b) reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending

physician or the registered nurse in the extended class attending the resident and the pharmacy service provider

Inspector #550 reviewed the medication incident reports for three specified months in 2018 and noted there were three medication incidents documented as follows:

Resident #016 was not administered a specified medication at a specified time the day; it was found still in its original packaging in the medication cart.

On a specified date, resident #027 was prescribed a medication at a specified strength, to be administered three times daily for a specified period of time. On the same day, the physician told RN #125 via a telephone order to change the first medication to another medication at the same dosage. The physician did not specify the frequency for administration and the RN did not clarify this with the physician. Resident #027 received the correct medication at the correct strength but at the wrong frequency for three days until the error was discovered by RN #125 on the fourth day and called the physician. The new medication should have been administered two times per day and it was administered three times.

Resident #028 was prescribed a specified medication at a specific dosage with orders to administer one tablet at bedtime. While signing the administration of the medication in the eMars, RPN #126 noted that they had administered two tablets of the medication instead of one tablet as per the physician's order.

The DOC indicated to the inspector that the immediate actions taken to assess and maintain the resident's health are documented in the resident's progress notes in Point Click Care (PCC). The notification to the resident, the SDM, the DOC, and the Medical Director/prescriber of the drug/resident's attending physician (all the same person in this home) are documented on the medication incident report by checking the appropriate box. The pharmacy service provider are notified at their quarterly Professional Advisory Council (PAC) meeting unless required earlier. All three medication incidents and progress notes were reviewed with the DOC:

Resident #016: there was no documentation of the immediate actions taken to assess and maintain the resident's health in the progress notes or on the medication incident report.

Resident #027: there was no documentation indicating that the resident/SDM was

notified and the immediate actions taken to assess and maintain the resident's health in the progress notes or on the medication incident report.

Resident #028: there was no documentation of the immediate actions taken to assess and maintain the resident's health in the progress notes or on the medication incident report.

The Director of Care told the inspector that the immediate actions taken to assess and maintain the resident's health were not documented for resident #016, #027 and #028. Resident #027 and the SDM were not notified of the medication incident. [s. 135. (1)]

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

During a review of the medication incident reports for the period of January, February and March 2018, the DOC indicated to inspector #550 that they review the medication incidents and adverse drug reactions, analyze and take corrective actions as soon as they receive them and documents this on the medication incident report and sign the reports.

The inspector noted that the analysis of the incidents for resident #027 and #028 were not documented on the incident reports and the corrective actions were not documented on the report for resident #027. Both incident reports were signed by the DOC. The DOC told the inspector that she did not complete and document an analysis of the incident for resident #027 and #028 as well as take corrective actions and document such for the incident involving resident #027. [s. 135. (2)]

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

During an interview, the DOC indicated to the inspector that all the medication incidents

are reviewed quarterly at their professional advisory council (PAC) meeting to identify any trends, reduce and prevent medication incidents and adverse drug reaction. Any changes and improvements identified are implemented and this is documented in the minutes of each meeting.

The inspector reviewed the minutes for the last quarterly PAC meeting which was held on May 28, 2018 and which included the medication incidents for the January to March 2018 quarter. Although there was documentation explaining what the three medication incidents discussed in previous findings above were about, the inspector was not able to find any documentation to indicate that a review of the incidents was conducted and that changes and improvements identified were implemented. The DOC was not able to provide any documentation to indicate that this was done. [s. 135. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is (a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to the resident, the resident's SDM, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action are taken as necessary, a written record is kept of everything and a quarterly review is undertaken of all medication incidents and adverse drug reactions that have occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions, any changes and improvements identified in the review are implemented, and a written record is kept of everything provided for, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 47. Qualifications of personal support workers

Specifically failed to comply with the following:

s. 47. (1) Every licensee of a long-term care home shall ensure that on and after January 1, 2016, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title,
(a) has successfully completed a personal support worker program that meets the requirements in subsection (2); and
(b) has provided the licensee with proof of graduation issued by the education provider. O. Reg. 399/15, s. 1.

Findings/Faits saillants :

1. The licensee specifically failed to ensure that every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2)

This inspection is related to log #004769-18.

This finding of non-compliance is related to a complaint for the year of 2013-2014. During this period of time, O.Reg 79/10, (consolidation period from December 17, 2012 to May 25, 2015, s. 47. (1) indicated:

Every licensee of a long-term care home shall ensure that on and after the first anniversary of the coming into force of this section, every person hired by the licensee as a personal support worker or to provide personal support services, regardless of title, has successfully completed a personal support worker program that meets the requirements in subsection (2).

A complaint was received from the Finance Management Branch (FMB) with concerns related to the laundry staff replacing the personal support workers (PSW) during breaks as a result of the 2013 and 2014 Annual Report Review conducted by FMB in December 2017.

Laundry Aide (LA) staff #123 was interviewed by inspector #550. The LA indicated to the inspector they have been employed in the home as LA since 2009 and that they work from 1900hrs to 2400hrs on weekdays and 1700hrs to 2300hrs on weekends. The LA told the inspector that they were never expected to replace the PSWs during their break

when they were working as LA in the home but was asked on a few occasion to work as PSW after their shift in the laundry ended when a PSW did not show up for work and they had no one to replace. This happened in 2013-2014 and the LA indicated her duties as PSW included providing personal care to residents such as changing briefs, toileting, providing perineal care and repositioning the residents. LA #123 told the inspector they do not have PSW certification or any other courses related to this position.

LA staff #124 was interviewed by the inspector. They indicated in 2013 and 2014 they were working as LA in the home and that they were never expected to replace the PSWs during their break. When they were delivering the laundry on the floors between 2200hrs and 2300hrs they were expected to respond to call bells if there were any and to notify the appropriate staff of the resident's needs. They would not provide any care to the residents. LA #124 told the inspector they never worked as PSW in the home.

The inspector reviewed the staffing schedules and time sheets from January 1, 2013 to December 31, 2014 with the assistance of HR staff #108. It was documented that LA #123 worked and was paid as PSW on the following dates:
May 10, 2013: 7.5hrs
May 21, 2013: 1.5hrs
July 12, 2013: 7.5hrs
August 31, 2013: 7.5hrs
September 17, 2013: 5.5hrs

During an interview, the Administrator told the inspector that LA #123 was asked on a few occasion to replace PSW shifts when they were short staff. The Administrator indicated that it was part of the LA routine to replace the PSWs during their breaks although they were not able to provide any documentation.

As evidenced, LA #123 worked as a PSW in the home without the required qualifications. [s. 47. (1)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 66. Designated lead

Specifically failed to comply with the following:

s. 66. (2) The designated lead must have,
(a) a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field from a community college or university; and O. Reg. 79/10, s. 66 (2).
(b) at least one year of experience in a health care setting. O. Reg. 79/10, s. 66 (2).

Findings/Faits saillants :

1. The licensee specifically failed to ensure that the designated lead for the recreational and social activities program have:
(a) a post-secondary diploma or degree in recreation and leisure studies, therapeutic recreation, kinesiology or other related field form a community college or university.

This inspection is related to log #004769-18.

A complaint was received from the Finance Management Branch (FMB) regarding the qualifications of the Director of Activities (DOA) for Sarsfield Colonial Home as a result of the 2013 and 2014 annual report review conducted by FMB in December 2017. Concerns have been identified regarding the qualifications of the Director of Activity who also worked as the Food Service Supervisor.

During an interview, the Director of Activity #101 indicated to inspector #550 having been the Director of Activity in the home since September 2011. From October 22, 2013 to October 26, 2014 they were away on parental leave during which time they were replaced by the Food Service Supervisor (FSS). During this period of time, the FSS worked two days per week in the position of FSS and three days per week in the position of Activity Director.

The Administrator #122 told inspector #550 during an interview that the Director of Activity #101 had left one month earlier than originally expected for their parental leave. Because they had had a bad experience with the person they had hired to replace the Director of Activity's previous parental leave, they decided not to recruit for this position as it was temporary for one year. They offered the position to the FSS who was already working two days per week in the home and they accepted. The Administrator #122 told the inspector that the FSS did not have a post-secondary diploma or degree in recreation and leisure studies or any other related fields.

As evidenced, the licensee did not ensure that for the period of October 2013 to October 2014, the Director of Activity had the proper qualifications. [s. 66. (2) (a)]

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 73. Staff qualifications
Every licensee of a long-term care home shall ensure that all the staff of the home, including the persons mentioned in sections 70 to 72,
(a) have the proper skills and qualifications to perform their duties; and
(b) possess the qualifications provided for in the regulations. 2007, c. 8, s. 73..

Findings/Faits saillants :

1. The licensee specifically failed to ensure that all staff of the home have:
(a) the proper skills and qualifications to perform their duties.

This finding is related to the qualifications of the RAI-MDS coordinator for the home.

The MOHLTC Resident Assessment Instrument Minimum Data Set (RAI-MDS) 2.0 Funding policy, effective April 1, 2013, released June 2013, indicated on page 6:
Every Long-Term Care Home implementing RAI-MDS will select a regulated or licensed health care practitioner for the role of RAI-MDS Coordinator. An outline of requirements, qualifications and responsibilities follows:
Requirements
-Current regulated or licensed health care practitioner, (including a social worker), who is registered/licensed to practice as such in Ontario.
-A minimum of three years clinical, project leadership or management experience
-Internal staff member who know the interdisciplinary team members and is familiar with Home policies on assessment and care planning process preferred.

During the resident quality inspection, inspector #550 noted errors in the coding in specified areas to resident #001 and #010 by the RAI-MDS coordinator #114.

During an interview, the Administrator #122 indicated to the inspector that the RAI-MDS coordinator #114 was hired as RAI-MDS coordinator on May 15, 2017.
The Administrator was not able to provide any documentation confirming that the RAI-MDS coordinator #114 was a current regulated or licensed health care practitioner. [s. 73.]

Issued on this 11th day of October, 2018

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOANNE HENRIE (550), AMANDA NIXON (148)
Inspection No. / No de l'inspection :	2018_619550_0009
Log No. / No de registre :	010358-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 1, 2018
Licensee / Titulaire de permis :	Taminagi Inc. 5 Loiselle Street, CP Box 2132, Embrun, ON, K0A-1W1
LTC Home / Foyer de SLD :	Sarsfield Colonial Home 2861 Colonial Road, P.O. Box 130, Sarsfield, ON, K0A-3E0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Chantal Crispin

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

Order / Ordre :

The licensee shall be compliant with s.17. (1) of the LTCHA.

Specifically the licensee shall ensure that the staff-resident communication and response system:
• in the tub and shower room on all three floors allows calls to be cancelled only at the point of activation.
• is available in the shower area on the 2nd floor.
• clearly indicate where the signal is coming from when activated.

In addition, the licensee shall implement a monitoring process for ensuring that the resident-staff communication and response system is kept in good repair.

Grounds / Motifs :

1. 1. The licensee specifically failed to ensure that the resident-staff communication and response system:
(c) allows calls to be cancelled only at the point of activation
(d) is available at each bath and shower location used by residents, and
(f) clearly indicates when activated where the signal is coming from

For the purpose of this report, the resident-staff communication and response system is also referred to as the call bell system.

During the initial tour of the home inspector #550 observed the following in the tub and shower rooms on all three resident floors:

1st floor tub and shower room:
Inspector #550 noted small black devices on the walls that looked similar to a door bell; one was located next to the shower area and one located next to the toilet. PSW #119 told the inspector this was to be used to alert staff that assistance was required. The inspector pushed the button on the device located next to the toilet and an alarm was activated. The annunciator indicated "alarm building front door, alarm spa room panic button 1st floor". The inspector pushed on that same button to cancel and the alarm did not cancel. PSW #119 was not sure how to cancel this alarm, indicating to the inspector to try pushing on the button which inspector did again and this still did not cancel the alarm even after being pushed a few times. The PSW indicated that maybe it needed to be cancelled at the nursing desk and proceeded to go to the nursing station, where there was a console on the wall with a key pad. The PSW attempted to cancel the alarm by entering a code and this did not work. The PSW then asked the RAI coordinator who was nearby if they knew what the code to cancel the alarm from the tub room was. The RAI coordinator indicated they were not sure and tried a code which cancelled the alarm.

2nd floor tub and shower room:
Inspector #550 observed there was no call bell in the shower area of this tub room. The same black device from the first floor tub and shower room was on the wall next to the toilet and the inspector pushed on the button to activate the alarm. An alarm sounded and an annunciator indicated "alarm building front door, alarm", the inspector was not able to hear the rest of the message as the sound of the alarm was very loud. PSW #121 indicated to the inspector that it was the alarm for the door on the lower level and left to attend to the alarm. The inspector took the staircase to go to the lower level floor and noted at the main entrance a male staff member attempting to cancel the alarm at this door. As the inspector continued to the lower level, the alarm was cancelled. The inspector met PSW #121 in the hallway on the lower level and was told by the PSW that the alarm had been from the staff entrance door located at the end of the hallway. The annunciator was not providing the accurate location of where

the alarm was coming from.

3rd floor tub and shower room:
Inspector #550 pushed on the black device on the wall next to the toilet. The alarm sounded and the annunciator indicated the same message as the 2nd floor tub and shower room. The inspector was not able to cancel the alarm at the point of activation, it had to be cancelled at the console which was located on the wall on the other side of the hallway next to a desk.

The inspector toured the tub and shower room on each floor accompanied by the Administrator #122. During this subsequent observation, the call bells in the tub and shower rooms could not be cancelled at the point of activation. They could only be cancelled by keying a code on the console located on the wall across the hall from the tub and shower rooms. The Administrator noted that the message from the annunciator was not providing clear directions as to where the alarm was coming from and indicated they would call the repair company. The Administrator also noted that there was no call bell in the shower area of the second floor tub and shower room.

As evidenced, the call bells in the tub and shower rooms on all three floors could not be canceled at the point of activation. There was no call bell in the shower area of the tub and shower room on the 2nd floor and it did not clearly indicate where the signal is coming from when activated.

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 2, indicating a pattern, as the non-compliance relates to resident-staff communication and response system in the tub and shower room on each unit. The compliance history is a level 4 as non-compliance with section 15(1) of O.Regulation 79/10 has been issued as follows:
- Compliance Order issued June 23, 2017, as a result of Resident Quality Inspection (RQI) #2017_619550_0015 with a compliance date of September 21, 2017,
- Compliance Order issued March 8, 2017, as a result of Resident Quality Inspection (RQI) #2017_548592_0005 with a compliance date of May 12, 2017, and
-Voluntary Plan of Correction issued December 1, 2016, as a result of Resident Quality Inspection (RQI) #2016_219211_0023. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_617148_0002, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall be compliant with s.15(1) of the LTCHA. Specifically, the licensee shall ensure:
1) Bed systems are evaluated in accordance with evidence-based practice to ensure that bed systems are re-evaluated when changes to the bed system occur. As it relates to rotating assist rails, all intermediate positions are evaluated and the zone specific test results are documented;
2) An interdisciplinary team conducts and documents all resident assessments including the risk-benefit assessment in accordance with prevailing practices. Resident assessments by the interdisciplinary team must be conducted prior to the application of bed rails; and
3) The written plan of care for each resident with bed rails in use, is based on an assessment of the resident and provides clear directions to staff as it relates to the use of bed rails.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that where bed rails were used, residents were assessed and the bed system was evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident, steps are taken to prevent resident entrapment,

taking into consideration all potential zone of entrapment; and other safety issues related to the use of bed rails are addressed, including height and latch reliability.

On Feb 6, 2018, the licensee was served with a compliance order pursuant to O. Reg. 79/10, s. 15 (1) as a result of a Follow Up Inspection #2018_617148_0002. The order type was as per LTCHA, 2007, s. 153 (1) (a), in that the licensee was ordered to take specified action to achieve compliance. The compliance order was to have been complied with by May 11, 2018.

The licensee was ordered, in part, to take the following action:
1. Re-evaluate all bed systems where bed rails are used in the home, in accordance with the Health Canada Guidance Document "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document). In consideration of rotating assist rails, all intermediate positions are to be evaluated;
2. Establish and implement a process for ensuring that any bed system failures are addressed immediately. Document corrective actions taken;
3. Maintain a bed system inventory that includes all relevant identifying information for each bed system in use for each resident. Ensure that a re-evaluation of a bed systems is completed as required;
4. Establish and implement a process for ensuring that all residents with bed rails are assessed in accordance with the 2003 FDA clinical guidance document;
5. The resident assessment along with the names of the team members who participate in the assessment and decision making process, including the risk benefit assessments, is to be documented;
6. Ensure that the interdisciplinary team assessment process identifies potential nursing/medical and environmental interventions or changes, which may serve as alternatives to bed rail use; and
7. Develop and implement a documented ongoing auditing process to ensure that all requirements of this compliance order are satisfied.

Residents #001, #003, #004, #007, #012, #014, #016, #025 and #026 were initially observed on a specified date and over the remaining course of the inspection to have bed rails in use. The following is a summary of the health care record review, observations and staff interviews related to the use of bed rails:

Resident #001 – was observed to have two rotating assist rails, while in bed, in

the guard position. Staff reported that the resident uses the bed rails for bed mobility. The resident was unable to describe the use of the rail. The plan of care indicated the resident use the rails to assist in repositioning while in bed.

Resident #003- has had two identified falls from bed in an identified period of time, and was observed to have one rotating assist rail in the assist position. Staff reported that the resident used the bed rail to reposition while in bed. The resident was unable to describe the use of the rail. The plan of care, under the item of falls, indicated that the resident met the requirements for the safe use of assisting rails and to have one side rail up as it related to the risk of falls and for repositioning in bed.

Resident #004 – had an air mattress and was observed with two rotating assist rails, one in the guard and one in the assist position. Staff reported that the resident was not able to use the bed rails and that both rails were applied at the family's request. Staff reported that when the resident was is in bed both bed rails are placed in the guard position. The plan of care indicated that the resident did not meet the requirements for the safe use of assisting rails.

Resident #007 - was observed with one rotating assist rail in the assist position. Staff reported that the resident used the rail in the assist position to sit up in bed from a supine position. The resident expressed a desire to have the rail but was not able to indicate the use of the rail. The plan of care indicates that the resident met the requirements for safe use of assisting rails. The plan of care indicated the use of one rail for bed mobility and for the resident's emotional comfort and security.

Resident #012 –was observed with one rotating assist rail, while in bed, in the assist position. Day staff reported that the resident used the rail in the assist position to assist in transfers in and out of bed. Evening staff reported that the resident will use the rail in both the assist and guard position; the resident will use the rail in the assist position for repositioning and the rail in the guard position for bed mobility when in bed. The resident was unable to describe the use of the rail. The plan of care, under the item of falls, indicated that the resident met the requirements for the safe use of assisting rails and use of bed rails for repositioning in bed.

Resident #014 – was observed with one rotating assist rail in the assist position. Staff reported that the resident will use the rail in both the assist and guard

position; the resident will use the rail in the assist position for repositioning and the rail in the guard position for bed mobility when in bed. The resident was unable to describe the use of the rail. The plan of care indicated that one bed rail is used to assist with repositioning and for emotional comfort and security.

Resident #016 – was observed to have one rotating assist rail in the assist position. Staff reported that the rail is placed in the guard position when the resident is in bed to assist with repositioning. The resident was unable to describe the use of the rail. The plan of care under items of transfer, bed mobility and falls, indicated the use of one rail. The plan of care under items of sleep and restraints indicated the use of two rails for safety.

Resident #025 – had a history of falls and was observed in bed with one assist rail in the assist position. Staff reported the resident used the rail to assist with transfers out of the bed. The resident was unable to describe the use of the rail. The plan of care, under the item of falls, indicated that the resident met the requirements for safe use of the rail for transfers and bed mobility.

Resident #026 – had a history of falls, and the resident's bed system was observed to have one rotating assist rail in the guard position. Staff reported the resident used the rails for repositioning. The resident was unable to describe the use of the rail. The plan of care, under the item of falls, indicated that the resident met the requirements for the safe use of assisting rails and to have one side rail up as it related to the risk of falls.

The Director of Care and RAI Coordinator were identified as the two leads responsible for the resident assessment required by O.Reg 79/10, s.15 (1) and the Compliance Order of February 6, 2018.

Inspector #148 spoke with the RAI Coordinator on June 5, 2018, who identified two newly developed tools for the resident assessment of bed rails. The first tool was titled, Assisting Rail and Bed Entrapment Risk Assessment (Risk Assessment) and the second titled, 7 Day Bed Safety Assessment/Bed Entrapment Record. The RAI Coordinator said that the nursing staff complete the 7 day observation record, after which, the RAI Coordinator will complete the Risk Assessment document. When all data is collected the RAI Coordinator and DOC would discuss the findings and decide if the resident can use the bed rails. The Inspector requested copies of the completed resident assessments for the sampled residents, as identified above. The RAI coordinator said that no

assessments had been completed for residents previously residing in the home and that assessments had only been initiated for newly admitted residents. The RAI Coordinator identified that a specified resident was the first resident to have an assessment initiated. It was described that the 7 day observation period had past and the Risk Assessment form had been completed but that there had been no discussion with the DOC about the data collected. In addition to this, the RAI Coordinator expressed that the assessment tools developed were not clear and that the RAI Coordinator had questions for the DOC regarding the tools implementation. In discussion of the tools, the RAI Coordinator was not able to identify where the benefits were reviewed or where a risk benefit assessment would be documented.

The Inspector discussed the resident assessment of newly admitted residents with the RAI Coordinator. The RAI Coordinator described that upon admission a discussion would be had with the family and/or resident along with a review of the record to assess if the resident could use bed rails. The RAI Coordinator described that bed rails may be applied to a newly admitted resident's bed system prior to the completion of the resident assessment.

The Inspector discussed the plan of care statements noted above, whereby the resident are identified as meeting the requirements for the safe use of bed rails. The RAI Coordinator said that this phrasing is taken from the previous resident assessment tool titled Assessment of Assisting Rail. This assessment was identified in the February 6, 2018 inspection report to not be compliant with section 15(1)(a) of O. Regulation 79/10. The RAI Coordinator reported that the Assessment of Assisting Rail tool has been used to assess new admissions. The Inspector reviewed the health care records of two identified residents, who were newly admitted to the home. In the record of one resident, the Assessment of Assisting Rail tool was completed on a specified date, indicating the use of one assist rail. In the record of the other resident, the Assessment of Assisting Rail tool was completed on a specified date, indicating the use of one assist rail.

Inspector #148 spoke with the home's Director of Care regarding the resident assessment for use of bed rails. The DOC confirmed that the Assisting Rail and Bed Entrapment Risk Assessment (Risk Assessment) and the 7 Day Bed Safety Assessment/Bed Entrapment Record were the tools available for the resident assessment related to bed rails. The DOC further reported that it was the DOC and the RAI Coordinator that composed the interdisciplinary team for the resident assessment. The DOC described that it was the DOC that developed

the tools to be used in the resident assessment; the Professional Advisory Committee and RAI Coordinator were provided with an opportunity for input. In review of the tools identified, the tools did not offer an area for the documented risk benefit assessment. When discussed, the DOC was unable to describe the risk benefit assessment or where the risk benefit assessment would be documented. In discussion of the resident assessment process in place, the DOC said that she was unaware of how many resident assessments had been completed but noted that the tools had been implemented about a month ago. The DOC described that the intent was to have the resident assessments completed for all existing residents in the home over the next quarter in conjunction with the Minimum Data Set (MDS) quarterly assessments; newly admitted residents would have a resident assessment on admission.

It was determined that the licensee had not established and implemented a process for the resident assessment in accordance with prevailing practices. At the time of the inspection no resident in the home with bed rails in use, had a completed resident assessment nor had a risk benefit assessment taken place. Further to this, it was demonstrated that the home continued to apply bed rails for newly admitted residents without a completed resident assessment and had intended for resident assessments, of those currently residing in the home, to be done over the next three months while bed rails continued to be in use. In addition, the plans of care do not provide for clear direction to staff on the use of the rotating assist rail or the position of the rotating assist rail when in use.

On June 6, 2018, inspector #550 interviewed the Operation Manager #132 in the presence of the Administrator #122 regarding the bed entrapment evaluation. The Operation Manager #132 informed the inspector that they had conducted the evaluation of the bed system with the assistance of maintenance person #133 in the home. They indicated having referenced to the Health Canada guidance document "Adult Hospital Beds: Patient entrapment Hazards, Side Rail Latching Reliability and Other Hazards" and used a cone and cylinder tool to conduct the evaluations. They provided the inspector with a document titled Facility Entrapment Inspection sheet, indicating this document was used to document the evaluation of the bed systems. The Operation Manager #132 explained to the inspector the legend for the codes used on the entrapment inspection sheet:
"L" indicated one full bedrail on each side of the bed
"SM" indicated one quarter rail in the middle part of the bed
"Med" or "M" indicated one small rail at the head of the bed

"D" indicated one small rail at the head of the bed on each side
"R" indicated removed
"I" indicated installed
"P" indicated pass and "F" indicated failed.

The inspector reviewed the facility entrapment inspection spreadsheet with the Operation Manager #132. The Operation Manager indicated that the home did not have any beds equipped with two half rails on one side of the bed therefore zone 5 was not applicable. During a tour of all the beds in the home, the inspector had observed that the only type of rails used in the home were rotating assist rails and one resident had one half bed rail. The inspector noted there was no documentation on the facility entrapment inspection sheets indicating rotary assist rails were used in the home and that they were evaluated in the three different positions. Rotating assist rails have three position; when in the assist position, the rail is in the vertical position at the head of the bed, when in the guard position, the rail is in the horizontal position in the middle part of the bed and when in the intermediate position, the rail is in a diagonal position (between the assist and the guard position) in the middle part of the bed. The Program Manager #132 told the inspector that they were not aware that the rotating assist rails had three different positions therefore they were only evaluated in the position they were in at the time of the evaluation.

It was documented on the inspection spreadsheet that the bed system evaluation was conducted on January 9 and 17 and March 12 and 13, 2018. The following was noted documented on this spreadsheet sheet and confirmed by the Operation Manager:

At the time of the bed system evaluation:

Bed #02 was not evaluated, it was documented on the inspection sheet that there were no bed rails on the bed at the time the evaluation was conducted. It was also documented on the inspection sheet that a small rail was installed after. Upon observation on June 5, 2018, the inspector noted that bed #02 was equipped with one rotating assist rail in the assist position at the head of the bed on the right side. The mattress was too long, it did not fit into the mattress keeper and it exceeded the deck frame of the bed by approximately two inches on the left side as it appeared that the mattress had slid off the frame.

Bed #21 was equipped with a full bed rail on each side of the bed (L), it had

passed all zones and both rails were removed after the evaluation. Upon observation on June 5, 2018, the inspector noted that bed #21 was now equipped with one rotating assist rail in the guard position in the middle part of the bed on the right side.

Bed #23, was equipped with a quarter rail in the middle part of the bed, it had passed all zones and after the bed system evaluation, the quarter rail was removed. Upon observation on June 5, 2018, the inspector noted that bed #23 was now equipped with one rotating assist rail in the guard position in the middle part of the bed on each side.

Bed #27 was equipped with one quarter rail in the middle of the bed (SM) and had passed all zones. Upon observation on June 5, 2018, the inspector observed bed #27 was equipped with a rotating assist rail in the guard position in the middle part of the bed on each side and had an air pressure relief mattress. The Director of Care #116 told the inspector that the air pressure relief mattress was installed on this bed on a specified date, after the bed system evaluation was made.

Bed #31 was equipped with a full bed rail on each side of the bed (L), it had failed zone 2 and the mattress needed to be replaced. Both bed rails were removed after the evaluation. Upon observation on June 15, 2018, the inspector observed that bed #31 was equipped with a rotating assist rail in the middle part of the bed on each side.

Bed #34 was equipped with 1 full rail on each side of the bed (L), had passed all zones and that after this evaluation, both rails were removed. Upon observation on June 5, 2018, the inspector noted that bed #34 was equipped with one rotating assist rail in the guard position in the middle part of the bed on the right side and that the mattress did not fit into the mattress keeper as it was too long.

Bed #41 was equipped with one small rail on each side at the head of the bed (D), had passed all zones and after the evaluation of this bed system, both bed rails had been removed. Upon observation on June 5, 2018, the inspector noted that bed #41 was equipped with one rotating assist rail in the assist position at the head of the bed on the right side. The inspector attempted to move the rail to the guard position but the rail would not go all the way down, it stopped before it could reach the guard position.

Bed #43 was equipped with a full bed rail on each side of the bed (L), it had failed zone 2, 3 and 4. The mattress was changed and both bed rails were removed after the evaluation. Upon observation on June 5, 2018, the inspector observed bed #43 was equipped with one rotating assist rail in the assist position at the head of the bed on the right side. When the inspector verified the rotating assist rail, it was loose.
Two specified residents were newly admitted and were observed to have bed rails in use. At the time of the inspection, no bed system evaluation had been completed for the newly admitted residents as the tool required to complete the evaluation was not accessible to the home as described below. The home had intended to continue the use of the bed rails without a bed evaluation was completed.

The Operation Manager indicated to the inspector that beds #02, #21, #23, #27, #34, #41, and #43 were not re-evaluated when modifications were made to those bed systems as they were not made aware of the changes. They had not been made aware that the rotating assist rail on bed #043 was defective.
The Operation Manager #132 further indicated that the home does not own the tool to evaluate the bed systems, they had borrowed it from another home and had returned it after they had completed the initial bed system evaluations on March 13, 2018. Because of this, no bed system was re-evaluated when changes were made or when a new bed system was created. As per a discussion with the Program Manager #132 and the HR/ED/H&S #108, the mattresses that required to be replaced were not replaced and there was no documentation to indicate when the new rails were installed.

Inspector #550 noted that the bed system documented on the "evaluation entrapment inspection sheet" at the time of the evaluation differed from what was observed on June 5 and 15, 2018 by the inspector. The Operation Manager #132 told the inspector that some of the beds and bed system have changed since the evaluation was conducted and that they were not made aware of the changes. They do not document the changes or have a bed system inventory that is kept up to date.

Room 102 had bed #04, now has bed #41 and the bed system was modified.
Room 204-2 had bed #06, now had bed #34 and the bed system was modified.
Room 101-1 had bed #24, now had bed #26 and the bed system was modified.

Room 105-1 had bed #31, now had bed #20 and the bed system was modified.
Room 300-1 had bed #20, now had bed #31 and the bed system was modified.

It was unknown if the above bed systems were still assigned to the same residents they were assigned to when the evaluation was conducted.

The severity of this issue was determined to be a level 2 as there was potential for harm to the residents. The scope of the issue was a level 3, indicating wide spread, as the non-compliance relates to each resident observe with bed rails in use. The compliance history is a level 4 as non-compliance with section 15(1) of O.Regulation 79/10 has been issued as follows:
- Compliance Order issued February 6, 2018, as a result of Follow Up Inspection #2018_617148_0002 with a compliance date of May 11, 2018; and
- Compliance Order issued June 23, 2017, as a result of Resident Quality Inspection (RQI) #2017_619550_0015 with a compliance date of September 21, 2017.

This matter will be referred to the Director to determine the need for further action. (550)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 06, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 1st day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Name of Inspector / Nom de l'inspecteur : Joanne Henrie

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