Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Public Copy/Copie du public

Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 10, 2018	2018_625133_0006	022265-17	Follow up

Licensee/Titulaire de permis

Kemptville District Hospital
2675 Concession Road P.O. Bag 2007 KEMPTVILLE ON K0G 1J0

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

Kemptville District Hospital
2675 Concession Road P.O. Bag 2007 KEMPTVILLE ON K0G 1J0

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

JESSICA LAPENSEE (133)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): April 3, 5, 6, 9, 2018

This Follow Up Inspection was in follow up to Compliance Order (CO) #001 issued as a result of inspection #2017_627138_0022, related to bed rail use. The CO was reissued as a result of this Follow Up inspection. As this was the licensee's third consecutive order pursuant to O. Reg. 79/10, s. 15 (1), the matter was referred to the Director for further action by the Director.

During the course of the inspection, the inspector(s) spoke with The Vice-President of Nursing and Clinical Services and the Chief Nursing Officer (the Administrator of the Long Term Care unit), the Manager of Nursing Services (the Director of Nursing and Personal Care of the Long Term Care unit), the Team Leader for the Long Term Care unit, registered and non-registered nursing staff within the Long Term Care unit, the Building Services Manager, a maintenance worker, and residents within the Long Term Care unit.

During the course of the inspection, the Inspector observed identified residents' bed systems, reviewed documentation related to the evaluation of all residents' bed systems, reviewed components of identified residents' health care records related to bed rail use, observed identified residents while in their respective beds with bed rails in use.

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to comply with compliance order (CO) #001 from inspection #2017_627138_0022. The CO was originally served on September 15, 2017, with a compliance date of December 01, 2017. The CO was amended, as per request from the licensee, on November 16, 2017. The amendment was in relation to the compliance date, which was extended to March 01, 2018. This was the licensee's second consecutive CO issued pursuant to O. Reg. 79/10, s. 15 (1)

The licensee was ordered to:

1. Evaluate all bed systems where bed rails are used in the home, in accordance with evidence-based practices; and ensure that the results of each bed system evaluation are documented. Resident #004's bed system shall be evaluated immediately.

2. Establish and implement a process for ensuring that any bed system failures are addressed immediately by taking the necessary corrective actions, in accordance with prevailing practices. All actions taken to address bed system failures are to be documented.

3. Ensure that when any modification is made to a bed system with bed rails in use (such as a change of mattress or bed rail, or the addition of an accessory), the resulting new bed system is evaluated, in accordance with evidence- based practices; and the results of the new bed system evaluation are documented.

4. Implement the documented interdisciplinary team assessment process that has been

developed by the home for all residents with one or more bed rails in use (including partial rails), and for all residents for which the use of one or more bed rails is being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the prevailing practices document "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (HBSW, FDA, 2003). As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

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

6. Ensure that the interdisciplinary team reassesses residents with one or more bed rails in use, at a minimum, whenever there is a change in the residents health status.

7. Ensure that the interdisciplinary team clearly documents the final results of the resident assessment or reassessment, including the risk-benefit analysis and ensuing recommendation(s).

8. Update the written plan of care based on the assessment or reassessment of the resident by the interdisciplinary team. Include all required information as specified in the FDA 2003 clinical guidance document.

The licensee completed steps 1,2,3, 6 and 8 in CO #001

The licensee failed to complete steps 4, 5, and 7 in CO #001. These steps are interrelated.

The licensee failed to complete step 4 in CO #001 regarding the development and implementation of a documented interdisciplinary team assessment process, including all factors, elements and conditions outlined in the prevailing practices document.

The licensee failed to complete step 5 in CO #001 regarding consideration of alternatives to bed rails. It is noted that this is a required component of the prescribed risk benefit assessment as per the prevailing practices document.

The licensee failed to complete step 7 in CO #001 regarding documentation of the risk benefit assessment. It is noted that a prescribed risk benefit assessment is to be documented as per the prevailing practices document.

Related to the bed rail use assessment process implemented by the home:

On April 3, 2018, the Inspector met with Nurse Manager (NM) #101 and Team Leader (TL) #102. The compliance order (CO) was reviewed and the 2003 FDA clinical guidance document was discussed. The TL indicated that they had developed the new "Bed Rail Risk Assessment" document. The TL indicated that they did not remember the 2003 FDA clinical guidance document and could not say if they had consulted it or not when developing the assessment. Related to part 4 of the CO, the TL indicated that the Inspector may not find a documented team decision to approve the use of bed rails for residents. The NM and the TL indicated that the decision to implement bed rail use for a resident is as per conversation between the Registered Practical Nurse (RPN) and the Physiotherapist (PT) on a resident's admission day. Related to part 7 of the CO, the TL indicated that the assessment process did not result if a documented risk benefit assessment. The NM indicated that another form would have to be created, in relation to the required risk benefit assessment.

On April 3, 2018, the Inspector met with PT #103. The PT indicated that they were the PT for one of the two identified groups of long term care residents. The PT indicated that they do not make decisions about bed rail use. The PT indicated that the decision to use bed rails for a resident is made by the RPN who conducts the admission process for a resident. The PT indicated that the decision to use bed rails for a resident would be captured in the resident's care plan, which they consult when conducting a resident's mobility assessment. The PT indicated that if bed rails were not in use for a resident, they may suggest the use of a bed rail during a transfer, when a staff member was present with a resident. The PT explained that they would not speak to the use of bed rails when a staff member was not present with a resident. The PT indicated that the mobility assessment process does not specifically consider a resident's potential risk factors related to bed rail use. The PT qualified that all staff have become more aware of the potential risks related to bed rail use. The PT indicated that they would have a conversation with nursing staff if bed rails were in use for a resident and they had concerns about something they may have noticed during the mobility assessment, such as if a resident was trying to climb out of bed.

On April 3, 2018, the Inspector met with PT #104. The PT indicated that they were the PT for the other group of long term care residents. The PT indicated that they assess residents for mobility and make recommendations related to the resident's mobility to the care team. The PT indicated that they were not involved with approving the use of bed rails for residents. The PT indicated that they would assess a resident within 72 hours of their admission. The PT indicated that the decision to use bed rails for a resident has been made prior to the resident's mobility assessment. The PT indicated that they may recommend the use of a bed rail for an assisted transfer, for example, when a staff member is with a resident, only for the task of a supported transfer. The PT indicated that they do not give an opinion about the use of bed rails overall.

On April 5, 2018, the Inspector met with Registered Practical Nurse (RPN) #105. The RPN indicated that they complete the "Bed Rail Risk Assessment" document for a resident upon the resident's admission, or if there are any changes, such as if a resident becomes less cognitively aware. The RPN indicated that for the initial assessment, the main factor is what the resident and or family of the resident feels is needed. The RPN indicated that if the resident and or family of the resident feels bed rails are needed, bed rails will be put into use for the resident after discussing what the risks are. The RPN indicated that the risks discussed are general risks related to bed rail use. The RPN indicated that at the time of admission, they do not yet know the resident, unless they have come from another unit within the Kemptville District Hospital. The RPN indicated that the resident or the resident's family informs them about what bed rails the resident may have used prior to admission and why. The RPN indicated that at that time, they do not know what the resident's individual risk factors may be with regards to bed rail use. The RPN indicated that the "Bed Rail Risk Assessment" is done and the decision to use bed rails is made before the PTs are involved. The RPN indicated that they do the assessment and they make the decision to implement bed rail use. The RPN and the Inspector discussed the requirement for a documented risk benefit assessment as per the 2003 FDA clinical guidance document. The RPN indicated that the "Bed Rail Risk Assessment" process does not result in a documented risk benefit assessment, including weighing the resident's individual risk factors related to bed rail use versus the benefits.

On April 6, 2018, the Inspector and Team Leader (TL) #102 reviewed the "Bed Rail Risk Assessment" and it was concluded that it did not include all of the factors prescribed by the 2003 FDA clinical guidance document. For example, the "Bed Rail Risk Assessment" did not include medical diagnosis, conditions, symptoms and/or behavioral symptoms. The TL indicated that all of the prescribed factors were captured in the "LTC/ CCP Admission Assessment and History", which was always completed on the resident's

admission day. The TL indicated that there was no documented expectation with regards to one assessment being completed before the other.

On April 6, 2018, RPN #105 indicated that as the "Bed Rail Risk Assessment" was shorter and based on discussion, it may be done before the "LTC/ CCP Admission Assessment and History" was completed and bed rails implemented for use. The RPN indicated it was dependent on the time of day the resident was admitted. In this way, all of the factors prescribed by the 2003 FDA clinical guidance document may not be considered prior to implementing bed rail use.

On April 6, 2018, RPN #105 clarified to the Inspector that they do not make decisions about bed rail use for a resident, in that bed rails are put into use for a resident as per the resident or the family's request. The RPN indicated that they may try to deter and suggest otherwise, however, it is as per the resident or family's wishes.

Over the course of the inspection, resident #001, #002 and #003 were observed in their respective beds with bed rails in use. Over the course of the inspection, documentation related to bed rail use for resident #001, #002 and #003's was reviewed by the Inspector and discussed with RPN #105, including the completed "Bed Rail Risk Assessment", "Bed Rail Consent" and "Bed Assessment Record". It could not be confirmed if the "LTC/ CCP Admission Assessment and History" was completed prior to, in tandem with, or after the "Bed Rail Risk Assessment" was completed, and bed rails implemented for use. It was confirmed that that an interdisciplinary team assessment process related to bed rail use, as prescribed by the 2003 FDA clinical guidance document, had not occurred for the three residents. For the three residents, it was confirmed that the bed rail use assessment process in place had not resulted in a documented risk benefit assessment, as prescribed by the 2003 FDA clinical guidance document, including: comparing the potential for injury or death associated with the use or non-use of bed rails and the benefit for an individual resident; identifying why other care interventions were not appropriate, or not effective if they were previously attempted, and determined not to be the treatment of choice for the resident. Finally, it was confirmed that an interdisciplinary team had not approved the use of bed rails for the three residents, as prescribed by the 2003 FDA clinical guidance document.

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

(1) that included:

- compliance order (CO) #001 issued May 5, 2017 with a compliance due date of July 28, 2017 (inspection #2017_627138_0012).

- compliance order (CO) #001 issued September 15, 2017 with a compliance due date of December 1, 2017 (inspection # 2017_627138_0022). The CO was amended, as per request from the licensee, on November 16, 2017. The amendment was in relation to the compliance date, which was extended to March 01, 2018 (inspection #2017_627138_0022 (A1)).

A third CO, pursuant to O. Reg. 79/10, s. 15 (1) will be issued to the licensee and a referral will be made to the Director for further action by the Director. [s. 15. (1) (a)]

Additional Required Actions:

CO # - 001 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.

Issued on this 10th day of May, 2018

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JESSICA LAPENSEE (133)
Inspection No. / No de l'inspection :	2018_625133_0006
Log No. / No de registre :	022265-17
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	May 10, 2018
Licensee / Titulaire de permis :	Kemptville District Hospital 2675 Concession Road, P.O. Bag 2007, KEMPTVILLE, ON, K0G-1J0
LTC Home / Foyer de SLD :	Kemptville District Hospital 2675 Concession Road, P.O. Bag 2007, KEMPTVILLE, ON, K0G-1J0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cathy Burke

To Kemptville District Hospital, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_627138_0022, CO #001;

Pursuant to / Aux termes de :

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

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

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

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

Order / Ordre :

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

Specifically the licensee must:

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

a) An individual resident assessment by an interdisciplinary team, including all specified factors, prior to the decision to use bed rails.

b) A documented risk benefit assessment following the resident assessment referenced above, as prescribed, including: the assessment of the relative risk of using bed rails compared with not using them for an individual resident; identification of why other care interventions are not appropriate, or not effective if they were previously attempted and determined not to be the treatment of choice for the resident; comparing the potential for injury or death associated with use or non-use of bed rails to the benefits for an individual resident.

c) Approval of the use of bed rails for an individual resident by the interdisciplinary team that conducted the resident's assessment.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #001 from inspection #2017_627138_0022. The CO was originally served on September 15, 2017, with a compliance date of December 01, 2017. The CO was amended, as per request from the licensee, on November 16, 2017. The amendment was in relation to the compliance date, which was extended to March 01, 2018. This was the licensee's second consecutive CO issued pursuant to O. Reg. 79/10, s. 15 (1)

The licensee was ordered to:

1. Evaluate all bed systems where bed rails are used in the home, in accordance with evidence-based practices; and ensure that the results of each bed system evaluation are documented. Resident #004's bed system shall be evaluated immediately.

2. Establish and implement a process for ensuring that any bed system failures are addressed immediately by taking the necessary corrective actions, in accordance with prevailing practices. All actions taken to address bed system failures are to be documented.

3. Ensure that when any modification is made to a bed system with bed rails in use (such as a change of mattress or bed rail, or the addition of an accessory), the resulting new bed system is evaluated, in accordance with evidence- based practices; and the results of the new bed system evaluation are documented.

4. Implement the documented interdisciplinary team assessment process that has been developed by the home for all residents with one or more bed rails in use (including partial rails), and for all residents for which the use of one or more bed rails is being considered. The process shall include an individual resident assessment and shall specifically include all factors, elements and conditions as outlined in the prevailing practices document Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings (HBSW, FDA, 2003). As well, the process shall consider the general guidance outlined within the Treatment Programs/Care Plans section of the FDA 2003 clinical guidance document.

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

6. Ensure that the interdisciplinary team reassesses residents with one or more bed rails in use, at a minimum, whenever there is a change in the residents health status.

7. Ensure that the interdisciplinary team clearly documents the final results of the resident assessment or reassessment, including the risk-benefit analysis and ensuing recommendation(s).

8. Update the written plan of care based on the assessment or reassessment of the resident by the interdisciplinary team. Include all required information as

specified in the FDA 2003 clinical guidance document.

The licensee completed steps 1,2,3, 6 and 8 in CO #001

The licensee failed to complete steps 4, 5, and 7 in CO #001. These steps are interrelated.

The licensee failed to complete step 4 in CO #001 regarding the development and implementation of a documented interdisciplinary team assessment process, including all factors, elements and conditions outlined in the prevailing practices document.

The licensee failed to complete step 5 in CO #001 regarding consideration of alternatives to bed rails. It is noted that this is a required component of the prescribed risk benefit assessment as per the prevailing practices document.

The licensee failed to complete step 7 in CO #001 regarding documentation of the risk benefit assessment. It is noted that a prescribed risk benefit assessment is to be documented as per the prevailing practices document.

Related to the bed rail use assessment process implemented by the home:

On April 3, 2018, the Inspector met with Nurse Manager (NM) #101 and Team Leader (TL) #102. The compliance order (CO) was reviewed and the 2003 FDA clinical guidance document was discussed. The TL indicated that they had developed the new "Bed Rail Risk Assessment" document. The TL indicated that they did not remember the 2003 FDA clinical guidance document and could not say if they had consulted it or not when developing the assessment. Related to part 4 of the CO, the TL indicated that the Inspector may not find a documented team decision to approve the use of bed rails for residents. The NM and the TL indicated that the decision to implement bed rail use for a resident is as per conversation between the Registered Practical Nurse (RPN) and the Physiotherapist (PT) on a resident's admission day. Related to part 7 of the CO, the TL indicated that the assessment process did not result if a documented risk benefit assessment. The NM indicated that another form would have to be created, in relation to the required risk benefit assessment.

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PT indicated that they do not make decisions about bed rail use. The PT indicated that the decision to use bed rails for a resident is made by the RPN who conducts the admission process for a resident. The PT indicated that the decision to use bed rails for a resident would be captured in the resident's care plan, which they consult when conducting a resident's mobility assessment. The PT indicated that if bed rails were not in use for a resident, they may suggest the use of a bed rail during a transfer, when a staff member was present with a resident. The PT explained that they would not speak to the use of bed rails when a staff member was not present with a resident. The PT indicated that the mobility assessment process does not specifically consider a resident's potential risk factors related to bed rail use. The PT qualified that all staff have become more aware of the potential risks related to bed rail use. The PT indicated that they would have a conversation with nursing staff if bed rails were in use for a resident and they had concerns about something they may have noticed during the mobility assessment, such as if a resident was trying to climb out of bed.

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indicated that the resident or the resident's family informs them about what bed rails the resident may have used prior to admission and why. The RPN indicated that at that time, they do not know what the resident's individual risk factors may be with regards to bed rail use. The RPN indicated that the "Bed Rail Risk Assessment" is done and the decision to use bed rails is made before the PTs are involved. The RPN indicated that they do the assessment and they make the decision to implement bed rail use. The RPN and the Inspector discussed the requirement for a documented risk benefit assessment as per the 2003 FDA clinical guidance document. The RPN indicated that the "Bed Rail Risk Assessment" process does not result in a documented risk benefit assessment, including weighing the resident's individual risk factors related to bed rail use versus the benefits.

On April 6, 2018, the Inspector and Team Leader (TL) #102 reviewed the "Bed Rail Risk Assessment" and it was concluded that it did not include all of the factors prescribed by the 2003 FDA clinical guidance document. For example, the "Bed Rail Risk Assessment" did not include medical diagnosis, conditions, symptoms and/or behavioral symptoms. The TL indicated that all of the prescribed factors were captured in the "LTC/ CCP Admission Assessment and History", which was always completed on the resident's admission day. The TL indicated that there was no documented expectation with regards to one assessment being completed before the other.

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On April 6, 2018, RPN #105 clarified to the Inspector that they do not make decisions about bed rail use for a resident, in that bed rails are put into use for a resident as per the resident or the family's request. The RPN indicated that they may try to deter and suggest otherwise, however, it is as per the resident or family's wishes.

Over the course of the inspection, resident #001, #002 and #003 were observed in their respective beds with bed rails in use. Over the course of the inspection, documentation related to bed rail use for resident #001, #002 and #003's was

reviewed by the Inspector and discussed with RPN #105, including the completed "Bed Rail Risk Assessment", "Bed Rail Consent" and "Bed Assessment Record". It could not be confirmed if the "LTC/ CCP Admission Assessment and History" was completed prior to, in tandem with, or after the "Bed Rail Risk Assessment" was completed, and bed rails implemented for use. It was confirmed that that an interdisciplinary team assessment process related to bed rail use, as prescribed by the 2003 FDA clinical guidance document, had not occurred for the three residents. For the three residents, it was confirmed that the bed rail use assessment process in place had not resulted in a documented risk benefit assessment, as prescribed by the 2003 FDA clinical guidance document, including: comparing the potential for injury or death associated with the use or non-use of bed rails and the benefit for an individual resident; identifying why other care interventions were not appropriate, or not effective if they were previously attempted, and determined not to be the treatment of choice for the resident. Finally, it was confirmed that an interdisciplinary team had not approved the use of bed rails for the three residents, as prescribed by the 2003 FDA clinical guidance document.

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

- compliance order (CO) #001 issued May 5, 2017 with a compliance due date of July 28, 2017 (inspection #2017_627138_0012).

- compliance order (CO) #001 issued September 15, 2017 with a compliance due date of December 1, 2017 (inspection # 2017_627138_0022). The CO was amended, as per request from the licensee, on November 16, 2017. The amendment was in relation to the compliance date, which was extended to March 01, 2018 (inspection #2017_627138_0022 (A1)).

A third CO, pursuant to O. Reg. 79/10, s. 15 (1) will be issued to the licensee and a referral will be made to the Director for further action by the Director. (133)

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 13, 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
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M5S-2B1
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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 10th day of May, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : JESSICA LAPENSEE

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