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 # / Registre no	Type of Inspection / Genre d'inspection
Jan 19, 2017	2016_230655_0015	013472-16	Resident Quality Inspection

Licensee/Titulaire de permis

Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner

2020 Fisher Drive Suite 1 PETERBOROUGH ON K9J 6X6

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

FOREST HILL
6501 CAMPEAU DRIVE KANATA ON K2K 3E9

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

MICHELLE JONES (655), JESSICA LAPENSEE (133), JOELLE TAILLEFER (211)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): November 21, 22, 23, 24, 25, 28, 29, 2016 and December 1 and 2, 2016.

During the course of the inspection, the inspector(s) spoke with residents and family members, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPN), Housekeeping staff, Maintenance Assistance, the Maintenance and Environmental Services Manager, the Registered Dietician, the Nutritional Care Manager, the RAI Coordinator, the Life Enrichment Coordinator, the Director of Care (DOC), the Assistant Director of Care (ADOC), and the Administrator. The inspectors also reviewed resident's health records, reviewed home policies and procedures, observed resident rooms and the delivery of care and services.

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

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

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails are used, 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.

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used "as a best practice document". The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States.

The companion documents referred to in the HC Guidance Document are identified as "useful resources" and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S., FDA, 2003). This document provides necessary guidance in establishing a clinical assessment where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an

individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including the resident’s medical needs, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety risks posed by using one or more bed rails. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident medical record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On November 22, 24, and 28, 2016, Inspector #655 observed the bed belonging to resident #002. On all three observations, two 1/4 length bed rails were observed to be in the up position.

During an interview on November 28, 2016, resident #002 indicated to Inspector #655 that the bed rails are in the up position most of the time. As far as resident #002 could recall, the bed rails had been used this way starting from the time of the residents' admission.

On review of resident #002s health record, Inspector #655 located a "Side-Rail Use Assessment Form". The document was observed to be incomplete in that there was no rationale for the assessment, no recommendations for the type of rails to be used, no indication as to whether bed rails were either desired by the resident or indicated at the time of the assessment, and no signatures. In addition, it was indicated on the assessment form that resident #002 was not assessed for the use of bed rails while in bed.

During an interview on November 28, 2016, RPN #110 acknowledged that the “Side-Rail Use Assessment Form” had not been properly completed for resident #002. RPN #110 was unable to locate any additional documentation demonstrating that a full resident assessment had been completed with regards to the use of bed rails. As per the interview, RPN #110 had never completed a “Side-Rail Use Assessment Form” for any resident in the home.

On November 29, 2016, Inspector #211 observed that resident #003 was lying in bed with both bed rails in the up position. During an interview, ADOC #123 indicated to

Inspector #211 that the "Side-Rail Use Assessment Form" was not completed for resident #003.

On the same day, DOC #100 confirmed that resident #002 was also not assessed for the use of bed rails before they were implemented. DOC #100 further acknowledged that no resident had been assessed for bed rails, unless they were considered to be restraining, prior to the initial implementation of the "Side-Rail Use Assessment Form" which had not been fully implemented to date due to the need for a bed system evaluation.

During an interview on December 1, 2016, DOC #100 explained that a "Side- Rail Use Assessment Form" had been provided to the home by their corporate office in late May or early June, 2016. DOC #100 explained that it was to be registered staff that completed the "Side-Rail Use Assessment Forms" in order to assess residents for bed rail use; and that the assessment could be completed in approximately 15-20 minutes. DOC #100 indicated that this "Side- Rail Use Assessment Form" was only temporarily implemented in July, 2016, prior to which time no resident was assessed specifically for the use of bed rails unless the rails were considered to be restraining.

During the interview on December 1, 2016, DOC #100 noted that at the top of the "Side-Rail Use Assessment Form", there is a space to identify if the bed system entrapment zones had been evaluated. DOC #100 explained to the Inspectors that when the "Side-Rail Use Assessment Form" was received by the home, none of the beds in the home with bed rails (bed systems) had been evaluated to ascertain if the potential zones of entrapment passed or failed the prescribed dimensional limit testing, as per the best practices guidance document from Health Canada, titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". As a result, arrangements were made to have all bed systems evaluated; and, it was decided that the resident assessment forms would not be put into use until after that evaluation had occurred.

The bed system evaluation occurred on July 13th, 2016 and 70 out of 160 bed systems were given a failing grade, as one or more of the potential zones of entrapment failed the dimensional limit testing. DOC #100 explained that a decision was made to officially halt the resident assessment process, until such time as corrective actions were taken and all bed systems with side rails were re-evaluated and given a passing grade.

DOC #100 indicated that registered staff felt uncomfortable speaking to the bed system evaluations when they had not done the testing themselves; and, also felt uncomfortable

discussing the resident assessment with families where beds had not been evaluated or had been evaluated and had been given a failing grade. DOC #100 clarified that at that time, the resident "Side-Rail Use Assessment Forms" that had been done up to that time were pulled from the resident's files, and were not considered to be complete.

On December 1, 2016, DOC #100 confirmed that the assessment process for residents with bed rails in use was still on-hold.

On December 1, 2016, DOC #100 provided Inspectors #655 and #133 with a copy of the licensee's "Side-Rail Use Assessment Form". Inspectors #655 and #133 reviewed the licensees' "Side-Rail Use Assessment Form" at that time, and found that it was not fully in accordance with the current prevailing practices identified in "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S. FDA, 2003), a companion to the HC Guidance Document. The resident assessment did not address the residents' sleep patterns or habits nor did it take into account the sleep environment or the residents' level of comfort in bed. No clear documentation of a risk-benefit analysis was observed.

During an interview on the same day, DOC #100 also acknowledged that the licensee's bed rail use assessment process does not require that the sleeping patterns and habits of the resident are necessarily observed or assessed; and that the current assessment process is not of an interdisciplinary nature. DOC #100 further indicated that there is no process in place to trial clinical and environmental interventions as alternatives to bed rails before there is a decision to use bed rails. Rather, it was confirmed that all residents are admitted into bed systems with usable bed rails on them.

On December 1, 2016, DOC #100 provided Inspector #133 with all of the "Side Rail Use Assessment Forms" that had been completed when the assessment form had been temporarily implemented. It was determined that the assessment process had been completed for only 25 residents, 23 of whom were in the home at the time of this inspection. Of those 25 assessment forms, only two were completed in full. The remaining assessment forms, including that belonging to resident #002, were incomplete in that they were missing information, such as no recommendation for the type of bed rail, no indication if the bed system entrapment zones had been checked, no indication of the rationale for bed rail use if it was recommended, or missing signatures.

Residents, including resident #002 and #003, were not assessed for the use of bed rails in accordance with prevailing practices to minimize risk to the resident.

In addition to providing guidance in establishing a clinical assessment where bed rails are used, the HC Guidance Document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools (the cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

As noted, all bed systems with bed rails on them in the home were evaluated in accordance with the methods outlined in the HC Guidance Document in July, 2016. The bed system evaluations were done by an outside service provider. The bed system evaluation document, provided to Inspector # 655 on November 28, 2016, by DOC #100 indicated that "if zones 1-4 pass entrapment testing a passing grade will be issued". As well, a note on the document indicated "if any zones between 1-4 fails entrapment testing a failing grade will be issued", and, "if zones 5,6 or 7 fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

As a result of the evaluation process, 70 out of 160 bed systems were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 1-4) exceeded the prescribed dimensional limits. The recommended solution for the 70 failed bed systems, from the outside service provider, was to replace the mattress with a specified brand and design of mattress.

During an interview with Maintenance Manager/Environmental Services Manager #131, DOC #100, and Administrator #132 on December 1, 2016, it was indicated to Inspectors #655 and #133 that modifications were made to four of the 70 failed bed systems (#542, #552, #127, #227) following the bed system evaluations conducted in July, 2016. On all four of the noted bed systems, the bed rails were changed. In addition, the mattress was replaced on bed system #552.

At the same time, it was confirmed that following the changes made to the four noted bed systems, the resulting new bed systems had not been evaluated in accordance with the HC Guidance Document, including the testing of zones 1-4, in order to minimize risk to the residents.

On December 1, 2016, Inspectors #133 and #655 were informed of additional corrective actions that had been taken that day, to prevent resident entrapment, with regards to the

bed systems that had been given a failing grade.

Administrator #132 informed the Inspectors that the mattresses had been replaced on seven of the 70 bed systems that had been given a failing grade (#350, #514, #513, #440, #450, #437a, and #452). According to Administrator #132, new mattresses put in place were of the specified brand and type recommended as the solution for bed systems that failed zone 2 exclusively. Only two of the seven bed systems which received a new mattress had failed zone 2 exclusively. The resulting seven new bed systems were not evaluated in accordance with the HC Guidance Document, including testing of zones 1-4, in order to minimize risk to the residents.

On December 2, 2016, through discussion with DOC #100 and review of documentation by Inspectors #133 and #655, it was established that since the July, 2016 bed evaluation process, a new bed system had been created in room #122. At the time of the evaluation process, the bed system that was in room #122 had been given a passing grade. In September, 2016, that bed system was relocated to another resident room; and, another bed system was moved into room #122. The bed system that was moved to room #122 had a specified type of mattress in place at the time of the bed evaluation process in July, 2016. DOC #100 informed the Inspector that the when this bed frame was moved into room #122, the mattress type changed. DOC #100 confirmed that the resulting new bed system in room #122 was not evaluated in accordance with the HC Guidance Document, including testing of zones 1-4, in order to minimize risk to the resident.

On December 2, 2016, DOC #100 explained to Inspector #133 that in July, 2016, the home had received a cone and cylinder tool, required for testing zones 1-4, but it had never been put into use. DOC#100 explained that the tool is shared with two of their sister homes, and that after approximately one month, the tool was sent to one of the other homes.

Over the course of the inspection, it was ascertained that where changes were made to a resident's bed system, such as a change of mattress or bed rails, the home did not have a process in place to ensure that the resulting new bed system was evaluated in accordance with evidence based practices, to minimize risk to the resident.

The licensee has failed to ensure that where bed rails are used, 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. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

In July, 2016, all bed systems with bed rails on them in the home were evaluated in accordance with the methods outlined in the HC guidance document. The bed system evaluations were done by an outside service provider.

During an interview on November 28, 2016, DOC #100 provided Inspector #655 with the bed system evaluation document. The bed system evaluation document indicated that "if zones 1-4 pass entrapment testing a passing grade will be issued". As well, a note on the document indicated "if any zones between 1-4 fails entrapment testing a failing grade will be issued", and, "if zones 5,6 or 7 fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

As a result of the evaluation process, 70 out of 160 bed systems (excluding bed systems with therapeutic air surfaces) were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 2-4) exceeded the prescribed dimensional limits. There were no zone 1 failures. The recommended solution for the 70 failed bed systems, from the outside service provider, was to replace the mattress with a specified brand and design of mattress. Bed systems that failed in zone 2 exclusively were to have one specified design of mattress, and all other bed systems that failed were to have a second specified design of mattress. In the mattress notes column of the bed system evaluation document, it is reflected that 53 of the 70

mattresses on bed systems that were given a failing grade were in poor condition, while two were in fair condition (455B and 422A) and 16 were in good condition (542A, 111A, 149B, 240A, 437B, 527B, 549A, 522A, 142A, 153A, 209B, 249A, 437A, 543A, 426A, 452A).

For two of the 70 failed bed systems (#426A and #422A), zone 7 also failed. Zone 7 is the potential zone of entrapment (for the head) between the headboard or foot board and the mattress end, and is indicative of a mattress that does not fit the bed frame. Related to the bed system #426A, the recommended solution also included changing the bed. Related to the bed system #422A, the additional notes indicated "short mattress".

One bed system (#327A), that did not include a therapeutic air surface, was given a passing grade but was noted to have failed zone 7. The recommended solution was to replace the mattress with a specified brand and type of mattress, and the additional notes for the bed system (327A) indicated "short mattress".

Related to bed systems that include a therapeutic air surface, five were given a passing grade; however, zones 2, 3 and 4 failed the dimensional limit testing (109B, 126A,155A, 341A, 414A). These bed systems were given a passing grade because the HC guidance document exempts such therapeutic air surfaces from the dimensional limit recommendations, except for the spaces within the perimeter of the rail (zone 1). The bed system evaluation document, in the solutions column, noted "LAL (partial exemption)" for these bed systems (LAL = low air loss). The HC document outlines (page 12 and 13) that this partial exemption is due to the highly compressible nature of these mattresses. As such, there is an inherent risk of entrapment in bed systems using these products with bed rails. Steps must be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During an interview on December 1, 2016, Inspectors #133 and #655 reviewed the outcomes of the July, 2016 bed system evaluation with Administrator #132, DOC #100, and Maintenance Manager/Environmental Services Manager #131. During the interview, it was confirmed to the Inspectors that with the exception of four bed systems (#542, #552, #127, #227), there had been no corrective actions or interventions implemented to date in relation to the failed potential zones of entrapment on the 76 identified bed systems (including the one bed system that was given a passing grade but failed zone 7; and the five bed systems with therapeutic air mattresses), to prevent resident entrapment. It was further confirmed that following changes made to the four noted bed systems, the resulting new bed systems had not been evaluated in accordance with the

HC document, including testing of zones 1-4, as is required by O. Reg. 79/10, s. 15 (1) (a), in order to minimize risk to the residents. It was explained to the Inspectors that the home shares the cone and cylinder tool required to test zones 1-4 with two of their sister homes. The tool was received by the home in July, 2016, but it was not put into use before it was sent to one of the other homes. During the same interview, it was also confirmed that none of the residents in the bed systems with failed potential zones of entrapment had been assessed in accordance with evidence based practices or prevailing practices, as is required by O. Reg. 79/10, s. 15 (1) (a).

In the afternoon of December 1, 2016, Inspectors #133 and #655 were informed of corrective actions being taken to prevent resident entrapment with regards to the bed systems that had been given a failing grade. Administrator #132 informed the Inspectors that bed rails had been removed from 11 of the 70 bed systems that had been given a failing grade; and that the mattress had been replaced on seven of 70 bed systems that had been given a failing grade. The Administrator confirmed that the new mattresses put in place were of the specified brand and type recommended as the solution for bed systems that failed zone 2 exclusively. Only two of the seven bed systems which received a new mattress had failed zone 2 exclusively. The resulting new bed systems were not evaluated in accordance with the HC document, including the testing of zones 1 -4, in order to minimize risk to the residents.

Upon becoming aware that a total of 76 resident's bed systems with bed rails in use (including one bed system which passed but failed zone 7; and, the five identified bed systems with therapeutic air mattresses in place) were evaluated to have one or more failed potential zones of entrapment in July, 2016, the licensee did not take steps to prevent resident entrapment, taking into consideration the failed potential zones of entrapment.

As the non compliance described above is widespread, and presents the potential for actual harm to the residents, a compliance order will be served on the licensee. [s. 15. (1) (b)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. During a tour of the home on November 21, 2016, Inspector #211 observed all five floors of the home. It was noted that each floor of the home has a South and North unit, and each unit has a separate dining room with a servery.

Inspector #211 observed on November 21, 2016, that residents can enter each of the north dining rooms on the third, fourth, and fifth floors, from five different access points: double doors from the television room, double doors from the resident hallway, a single door from the elevator hallway and a single door from the service elevator alcove, which leads directly to the area of the servery. All doors were observed to be open and unlocked, except the single door from the service elevator alcove which leads directly to the area of the server, which was closed but unlocked.

Inspector #211 observed on November 21, 2016, that residents can enter the south dining room on the third floor from three different access points: double doors from the television room, one single door from the unit and one single door from the elevator hallway. All doors were observed to be open and unlocked, except the single door from the elevator hallway which was closed but unlocked.

Inspector #211 observed on November 21, 2016, that residents can enter the south dining rooms from three different access points on the fourth and fifth floors: double doors from the television area, a single door from the hallway close to the elevator, and through an open area between the resident sitting area on the unit and the dining room. All doors were observed to be open and unlocked, except the single door from the hallway close to the elevator which was closed but unlocked.

The serveries were observed to have open access to the dining room, with no system to limit their access when not in use.

At the same time, Inspector #211 observed that each of the accessible serveries had steaming wells and functional toasters that were directly accessible to residents from the

dining rooms. The serveries in the North unit dining rooms on each floor were also observed to have a functional coffee/hot water machine with an accessible push button that, when pressed, dispenses boiling water. Residents were observed to be in the dining rooms without supervision on November 21 and November 28, 2016.

On November 21, 2016 at 1000 hours, Inspector #211 observed the dining room area on the south unit on the second floor, a secure unit. The doors to enter the dining room from the resident's unit hallway and from the television room were observed to be closed; but were both unlocked. The toaster in the dining room was operational and became hot when the handle was pressed. At the same time, Inspector #211 observed resident #018 opening the door from the television room to the dining room while interviewing PSW #102 related to the unlocked doors in the dining room.

During the interview, PSW #102 indicated that the door from the resident's unit hallway was normally locked, but the locking mechanism was not functioning properly. PSW #102 indicated that the door between the television room and the dining room on the second floor should be closed and locked at all times for safety reasons.

During an interview on November 21, 2016, RPN #103 and DOC #100 indicated that all the dining room doors on the third, fourth and fifth floors are always kept open and unlocked; and that the dining rooms are accessible to residents at all times, including when they are unsupervised. RPN #103 acknowledged that residents with cognitive impairment have the potential to burn themselves on the steaming wells, the coffee/hot water machines and/or the toasters.

During an interview on November 21, 2016, the RD indicated to Inspector #211 that residents could potentially burn themselves on the steam well and/or the coffee/hot water machine because the dining rooms are not supervised after the meals are completed.

The licensee has failed to ensure that the home is a safe and secure environment for its residents. [s. 5.]

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 ensuring that the home, including the dining areas, is a safe and secure environment for its residents, to be implemented voluntarily.

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. (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).

Findings/Faits saillants :

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

The plan of care for resident #006 indicates that the resident is to wear a safety device at all times when seated.

Inspector #655 observed the safety device of resident #006 to be loose more than once over the course of a day shift on three different days, with enough space to allow the Inspector to place up to four fingers between the resident and the safety device. A staff member was made aware of the loose fit of the safety device at the time of each observation.

In resident #006s' care plan, it is indicated that staff are to ensure the safety device is

applied properly, secured with 2 finger widths of space available between the safety device and the residents' body.

During an interview on November 24, 2016, PSW #125 indicated to Inspector #655 that all safety devices of this type are expected to be applied with just enough space to allow two fingers to fit between the resident and the safety device. At the time of the interview, PSW #125 demonstrated that three fingers could be fit between resident #006 and the safety device, acknowledging that the safety device fit more loosely than expected. PSW #125 acknowledged, however, that for resident #006, this is how the safety device is normally applied for resident #006 due to the residents' preference for a looser fit.

On the same day, PSW #106 told Inspector #655 that there should be a hands-width space between resident #006 and the safety device.

During interviews on November 24 and November 25, 2016, RPNs #103 and #124, respectively, indicated to Inspector #655 that resident #006s safety device is expected to be applied with just enough space to allow two fingers to fit between the resident and the safety device, as stated in resident #006s care plan.

During an interview on November 25, 2016, DOC #100 indicated that safety devices of this type are expected to be applied with a two-finger width space as per resident #006s care plan; and that if the safety device becomes loosened, it is expected to be tightened accordingly on hourly checks.

The licensee has failed to ensure that the care set out in the plan of care related to the application of resident #006s' safety device is provided to resident #006 as specified in the plan. [s. 6. (7)]

2. The licensee has failed to ensure that the plan of care is revised when the resident's care needs change or care set out in the plan is no longer necessary.

Resident #001 was identified to be at risk for altered skin integrity.

Inspector #655 reviewed resident #001s medical record. There were several specific interventions in resident #001s care plan related to skin care.

On November 25 and again on November 28, 2016, Inspector #655 observed that the specified interventions were not being provided as per the care plan.

During an interview on November 25, 2016, PSW #114 was unable to speak to any specific interventions in the plan of care for resident #001 related to skin care. PSW #114 acknowledged that resident #001 had a history of altered skin integrity but indicated that there were no active skin concerns at the time of the interview.

During an interview on November 25, 2016, PSW #122 was also unable to speak to any specific interventions in the plan of care for resident #001 related to skin care. On review of resident #001s current care plan, PSW #122 acknowledged that the interventions identified in the care plan were no longer required.

During an interview on November 25, 2016, both RPN #113 and RPN #121 indicated that the interventions related to skin care, as they are outlined in the care plan of resident #001, are no longer being implemented. Both RPNs indicated that resident #001s care plan was likely outdated.

During an interview on November 30, 2016, Administrator #132 indicated that the interventions related to skin care should have been removed from resident #001s care plan. According to Administrator #132, resident #001s care plan had not been revised when the interventions related to skin care were no longer necessary.

The licensee failed to ensure that the plan of care was revised when the care set out in resident #001s care plan related to skin care was no longer necessary. [s. 6. (10) (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 ensuring that the care set out in the plan of care for residents, including resident #006, as specified in the plan; and that the plan of care is revised for residents, including resident #001, when the care set out in the plan is no longer necessary, to be implemented voluntarily.

WN #4: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

s. 9. (2) The licensee shall ensure there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents. O. Reg. 363/11, s. 1 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On November 21, 2016, at 1000 hours, Inspector #211 observed three residents sitting in

the television room on the North side of the second floor. At the same time, Inspector #211 observed that a closet door was open and unlocked in the television room. Inside the closet, there were multiple pieces of equipment and supplies that were piled on top of each other.

On November 21, 2016, at 1030 hours, Inspector #211 observed two residents sitting in the television room on the North side of the fifth floor. At the same time, Inspector #211 observed a closet door was open and unlocked in the same room. Inspector #211 observed that the closet contained multiple boxes piled on top of each other.

During an interview on November 21, 2016, RPN #105 indicated that the closet was used for activity storage and that the door should be closed and locked at all times. RPN #105 acknowledged that it is a potential safety issue when the door is unlocked.

During an interview on November 21, 2016 at 1230 hours, DOC #100 also observed that the closet door in the television room on the north side of the second floor was open and unlocked. Inspector #211 observed that residents were sitting in the area at the same time. DOC #100 stated that the closet was used for activity storage and the door should be closed and locked at all times. DOC #100 acknowledged that the equipment and supplies inside the storage room/closet were stored in an unsafe condition for the residents. DOC#100 also indicated that all activity storage room doors, on each floor, should be closed and locked when not in use by the activity staff.

The licensee has failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff. [s. 9. (1)]

2. The licensee has failed to ensure that there is a written policy that deals with when doors leading to secure outside areas must be unlocked or locked to permit or restrict unsupervised access to those areas by residents.

On November 21, 2016 at 1000 hours, Inspector #211 observed two residents sitting in the television room on the South side of the fifth floor. The door leading to the balcony from the above television room was closed but unlocked.

During an interview on November 21, 2016, RPN #105 made the same observation and indicated that the balcony door from the above area should be closed and locked at all times.

On the same day, DOC #100 was informed by RPN #105 that the door leading to the balcony from the television room was found unlocked.

During an interview, DOC#100 and Administrator #132 indicated that the home did not have a written policy that deals with the doors leading to the balcony. [s. 9. (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 , ensuring that all doors leading to non-residential areas, including storage rooms, are kept closed and locked when they are not being supervised by staff; and that there is a written policy that deals with when doors leading to secure outside areas, including doors leading to a secure balcony, must be unlocked or locked to permit or restrict unsupervised access to those areas by residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 23. Every licensee of a long-term care home shall ensure that staff use all equipment, supplies, devices, assistive aids and positioning aids in the home in accordance with manufacturers' instructions. O. Reg. 79/10, s. 23.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use all equipment in the home in accordance with manufacturer's instructions.

On November 22, 2016, Inspector #211 observed that resident #007's therapeutic mattress was too short for the bed frame that it was on. At the same time, resident #007's bed rails were observed by Inspector #211 to be in the up position.

On November 30, 2016, Inspector #211 was provided with a copy of the user manual for the bed frame used for resident #007. On page two of the manual, in the "Important Precautions" section, there was a warning of possible injury or death related to the size of the mattress. The warning read, in part, "use a mattress that is properly sized to fit the mattress deck", and, "length should match the mattress support platform. Use of an improperly fitted mattress could result in injury or death".

During a discussion with Administrator #132, DOC #100, and Maintenance Manager/Environmental Services Manager #131, on December 1, 2016, Inspectors #655 and #133 were informed that resident #007 had brought the mattress into the home when admitted. It was acknowledged that resident #007's therapeutic mattress did not fit the frame it was currently on.

On December 2, 2016, Inspector #655 measured the gap between the head of the mattress and the head of the bed frame on resident #007's bed to be eight inches. In the HC Guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008", this area is otherwise known as potential entrapment zone 7, which may present a risk of head entrapment. As per the Health Canada Guidance Document, four and three quarter inches is the dimension used to represent the head with regards to potential entrapment zones where there is a risk of head entrapment.

On December 6, 2016, Administrator #132 informed Inspector #133 via email that a wedge had been secured into place on resident #007's bed to close the gap between the head of the mattress and the head of the bed frame.

The licensee failed to ensure that resident #007's therapeutic mattress was properly sized to the mattress deck in accordance with the manufacturer's instructions. [s. 23.]

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 , ensuring that staff use all equipment in the home, including bed systems with therapeutic surfaces such as air mattresses, in accordance with manufacturers' instructions, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs are stored in an area or a medication cart which is used exclusively for drugs and drug-related supplies.

i. On November 25, 2016, and again on November 28, 2016, Inspector #211 observed that residents' personal items (eye glasses, for example) were stored in a medication cart on the first floor, in the same drawer as the medications.

During an interview on November 25, 2016, RPN #110 indicated that residents' personal items such as eye glasses are kept in the medication cart to prevent losing them.

During an interview on November 28, 2016, RPN #109 indicated that personal items belonging to two residents were kept in the medication cart on the first floor when they were not in use by the residents.

On November 28, 2016, Inspector #211 observed a second medication cart located on the second floor.

During an interview at the same time, RN #117 indicated that the personal items belonging to three different residents were kept in the medication cart when they were not in use by the residents.

On November 28, 2016, Inspector #211 observed a third medication cart located on the fourth floor. During an interview at the same time, RPN #119 indicated that personal items belonging to one resident are kept in the medication cart when they were not in use by the resident.

In all three instances, Inspector #211 observed that the residents' personal items were stored in the exact same drawer as the medications.

During an interview on November 28, 2016, DOC #100 indicated that the residents' personal items should not be kept in the medication cart.

ii. On November 25, 2016, Inspector #211 observed five cans of unopened coke in the medication fridge located in the medication room on the first floor.

During an interview on November 25, 2016, RPN #110 stated that the cans of coke are kept in the medication fridge for resident #017.

During an interview on November 28, 2016, DOC #100 indicated that the cans of coke should not be kept in the medication fridge.

The licensee has failed to ensure that drugs are stored in an area or a medication cart which is used exclusively for drugs and drug-related supplies. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs are stored in an area or a medication cart that is secure and locked.

i. Inspector #655, on November 22, 2016, and Inspector #211 on November 25, 2016,

observed a prescribed topical medication belonging to resident #019 to be located on the bathroom counter in resident #019's shared bathroom.

During an interview on November 25, 2016, PSW #114, and RPN #113 indicated to Inspector #211 that resident #019's prescribed topical medication should not have been left in the resident's room.

During an interview on November 25, 2016, DOC #100 confirmed that prescribed topical medications should be stored in an area that is secure and locked; and not in resident rooms.

ii. Inspector #211 reviewed the medical record of resident #009 and noted a physician's order which indicated that resident #009 may self-administer a prescribed medication.

During an interview on November 25, 2016, RPN #110 indicated to Inspector #211, that resident #009 had a self-administration order for a specified medication, and for this reason, the specified medication was kept in resident #009s room.

During an interview on November 25, 2016, RPN #113 found the specified medication belonging to resident #009 in an unlocked container on top of resident #009s night table. RPN #113 was not aware that the medication was being kept in resident #009s room.

Inspector #211 reviewed the home's policy, #5-5, titled "Self-Administration of medications" dated 2014. It was specified in the policy that the prescriber indicates the amount of medication allowed to be securely stored at the bedside, if other than a standard size package.

During an interview, DOC #100 indicated that where a resident is self-administering a medication as prescribed, the medication should be placed in a secure and locked container in the resident's room.

The licensee has failed to ensure that resident #019's and resident #009's medications were stored in an area or a medication cart that is secure and locked. [s. 129. (1) (a)]

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 , ensuring that all drugs are stored in an area or medication cart which is used exclusively for drugs and drug-related supplies; and that all medications are stored in an area or medication cart that is secure and locked, including those medications belonging to residents #009 and #019, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the home, furnishings and equipment are kept clean and sanitary.

On November 22, 2016, Inspector #655 observed resident equipment to be unclean including the walker belonging to resident #002 and the wheelchair belonging to resident #006.

At the time of these observations, resident #002s' walker was observed to have extensive white stains and small brown debris on the seat of the walker; and resident #006s' wheelchair was observed to have dried debris on the lower frame, stains on the armrests, and white stains and dried debris on the seat cushion.

Inspector #655 reviewed the cleaning schedule ("Night Duties Log Sheet") for resident #002s' home area. Where resident #002s' walker was listed for cleaning on a specified day, there was no signature or other documentation to indicate whether or not the cleaning of resident #002s' walker took place as scheduled.

During an interview on November 24, 2016, PSW #129 indicated that without a signature, there was no way to determine whether or not resident #002s walker had been cleaned as per the schedule.

During an interview on November 25, 2016, PSWs #112 and #114 acknowledged that the walker belonging to resident #002 remained unclean. Inspector #655 observed the walker belonging to resident #002 to remain unclean still on November 24, 25, and 28, 2016.

The policy document titled "Procedure for Care/Cleaning of Wheel/Geri Chairs", Policy # CS-18.4 dated January, 2011 was reviewed by Inspector #655. According to the policy, all chairs must be clean at all times. The surfaces and armrests of each chair are to be cleaned daily by the nursing staff; and, a thorough cleaning of all chairs is to be completed by nursing staff weekly as per an established cleaning schedule.

Inspector #655 reviewed the cleaning schedule ("Night Duties Log Sheet") for resident #006s' home area. According to the cleaning schedule, resident #006s' wheelchair was scheduled to be cleaned on a specified date.

On November 25 and again on November 28, 2016, resident #006s' wheelchair was still observed to be unclean; with the same stains and debris on several surfaces of the chair, including the armrests.

The licensee failed to ensure that the walker belonging to resident #002 and the wheelchair belonging to resident #006 was kept clean and sanitary. [s. 15. (2) (a)]

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the use of a Personal Assistance Services Device (PASD) has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent.

On November 22, 2016, Inspector #655 observed the bed belonging to resident #002 to have two 1/4 length side rails in the up position.

The care plan indicated that the right bed rail was to be in the up position to assist with bed mobility.

During an interview on November 28, 2016 resident #002 indicated that the bed rail is

used for bed mobility. Resident #002 could not recall being asked about the use of bed rails, explaining that they had been in place since admission. Resident #002 was not sure if the bed rails could be released without assistance. At the time of the interview, both of resident #002s bed rails were observed again to be in the up position.

Inspector #655 reviewed the residents medical record and was unable to locate any documentation to demonstrate that consent for the use of the bed rail PASD had been obtained.

During an interview on November 28, 2016, RPN #110 indicated that resident #002 uses the bed rails for mobility reasons; and also referred to the bed rails as a PASD. According to RPN #110, the use of a PASD - including the use of bed rails for resident #002 - must have been consented to by the resident or, if the resident is incapable, a substitute decision-maker.

RPN #110 provided Inspector #655 with a document titled "Side-Rail Use Assessment Form" for resident #002. RPN #110 reviewed this document with the inspector. Page two of this document includes the following statement: "The positive and negative aspects of side rail use have been discussed with the resident and/or family, and the resident and/or responsible parties are aware of the risks involved with side rail use". There was no date and no signatures to indicate that the information had been provided to the resident and/or substitute decision-maker as stated on the form. RPN #110 acknowledged that, based on this document, it could not be confirmed that consent had been obtained for the use of the bed rail PASD for resident #002.

During an interview on November 29, 2016, both DOC #100 and ADOC #123 acknowledged that consent had not been obtained for the use of the bed rail PASD for resident #002 as of yet.

The licensee has failed to ensure that the use of a bed rail PASD had been consented to by resident #002 or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. [s. 33. (4) 4.]

Issued on this 20th day of January, 2017

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) :	MICHELLE JONES (655), JESSICA LAPENSEE (133), JOELLE TAILLEFER (211)
Inspection No. / No de l'inspection :	2016_230655_0015
Log No. / Registre no:	013472-16
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 19, 2017
Licensee / Titulaire de permis :	Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner 2020 Fisher Drive, Suite 1, PETERBOROUGH, ON, K9J-6X6
LTC Home / Foyer de SLD :	FOREST HILL 6501 CAMPEAU DRIVE, KANATA, ON, K2K-3E9
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Susan Bell

To Omni Health Care Limited Partnership on behalf of 0760444 B.C. Ltd. as General Partner, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is ordered to:

1. Implement appropriate interventions to mitigate the risk of entrapment for all residents who use one or more bed rails where a bed system is known to have failed the testing of one or more zones of entrapment. The risk interventions identified in the HC Guidance Document companion document, "A Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (U.S. FDA June, 2006), shall be considered for each resident and their bed system, including those bed systems with a therapeutic surface such as a low air loss mattresses (LAL). This will be done using an individualized, systematic and documented approach. These actions must be completed within seven days of this order being served.

2. Re-evaluate all bed systems where bed rails are used in the home, in accordance with evidence-based practices. This must be completed within 14 days of this order being served.

3. Establish and implement a process for ensuring that all future bed system failures, including failures identified as a result of the re-evaluation of bed systems as ordered, are addressed immediately by taking the necessary corrective actions in accordance with the HC companion document titled "A

Guide for Modifying Bed Systems and Using Accessories to Reduce the Risk of Entrapment" (U.S. FDA June, 2006). Ensure that when any modification is made to a bed system with bed rails in use (such as a change of mattress, use of therapeutic surfaces, a new type of bed rail is put into place, or an accessory is added), the resulting new bed system is evaluated in accordance with evidence-based practices in order to minimize risk to the resident. The evaluation must be conducted prior to the bed system being used by the resident, and must be documented.

4. Ensure that the outcomes of bed system evaluations, including those conducted internally and those conducted by external providers, are communicated to staff, specifically the individual(s) responsible for correcting the matter of concern.

5. Amend the home's existing "Side-Rail Use Assessment Form" (bed rail assessment form) in accordance with the prevailing practices outlined in "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S.F.D.A, April 2003), a companion document to the Health Canada Guidance Document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC Guidance Document). The amended bed rail assessment form shall formally capture a risk-benefit analysis related to the use of bed rails for each resident and shall, at a minimum, include questions that can be answered by an interdisciplinary team of assessors related to:

a) the resident while sleeping for a specified period of time to establish their habits, patterns of sleep, level of comfort in bed, behaviours and other relevant factors prior to the application of any bed rails; and,
b) the alternatives that were trialed prior to using one or more bed rails, and the effectiveness of those alternatives during a specified observation period.

6. Ensure that an interdisciplinary team assesses all residents in the home who use one or more bed rails using the amended bed rail assessment form; and, ensure that all residents hereafter are assessed before the decision to use or discontinue the use of a bed rail is made. The names of the interdisciplinary team members who participate in the assessment, the results of the assessment, and ensuing recommendations are to be documented on the assessment form for each resident.

7. Reassess all residents for the use of bed rails, at a minimum, whenever there is a change in the resident's physical condition, as recommended in the HC Guidance Document. Update the written plan of care based on the resident assessment for all residents where bed rails are used. Provide clear directions (type of rail, for example) and include in the written plan of care any necessary accessories or interventions that are required to mitigate any identified bed safety hazards.

8. Update the existing policy, #HLHS-TP-4.10, titled "Resident Entrapment Hazards", dated January, 2016; or, create a new policy that addresses the procedural considerations in assessing residents for the use of bed rails, in accordance with the document titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Homes, and Home Care Settings" (U.S. F.D.A, April 2003).

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails are used, 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.

On August 21, 2012, a notice was issued to Long Term Care Home Administrators from the Ministry of Health and Long Term Care, Performance Improvement and Compliance Branch identifying a document produced by Health Canada (HC) titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability and Other Hazards, 2008" (HC Guidance Document). In the notice, it is written that this HC Guidance Document is expected to be used "as a best practice document". The HC Guidance Document includes the titles of two additional companion documents by the Food and Drug Administration (FDA) in the United States.

The companion documents referred to in the HC Guidance Document are identified as "useful resources" and outline prevailing practices related to the use of bed rails. Prevailing practices are predominant, generally accepted and widespread practices that are used as a basis for clinical decision-making.

One of the companion documents is titled "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S., FDA, 2003). This document provides necessary

guidance in establishing a clinical assessment where bed rails are used. In this document, it is recommended that any decision regarding the use of bed rails be made within the context of an individualized resident assessment, to assess the relative risk of using bed rails compared with not using bed rails for each individual resident. This process is to involve a comparison between the potential for injury or death associated with the use or non-use of bed rails and the benefits for an individual resident. The assessment is to be conducted by an interdisciplinary team taking into consideration numerous factors including the resident's medical needs, sleep habits and patterns, sleep environment, resident comfort in bed, and potential safety risks posed by using one or more bed rails. The document further indicates that the risk-benefit assessment that identifies why other care interventions are not appropriate or not effective is to be documented in the resident medical record. The decision to use bed rails is to be approved by the interdisciplinary team; and the effectiveness of the bed rail is to be reviewed regularly.

On November 22, 24, and 28, 2016, Inspector #655 observed the bed belonging to resident #002. On all three observations, two 1/4 length bed rails were observed to be in the up position.

During an interview on November 28, 2016, resident #002 indicated to Inspector #655 that the bed rails are in the up position most of the time. As far as resident #002 could recall, the bed rails had been used this way starting from the time of the residents' admission.

On review of resident #002s health record, Inspector #655 located a "Side-Rail Use Assessment Form". The document was observed to be incomplete in that there was no rationale for the assessment, no recommendations for the type of rails to be used, no indication as to whether bed rails were either desired by the resident or indicated at the time of the assessment, and no signatures. In addition, it was indicated on the assessment form that resident #002 was not assessed for the use of bed rails while in bed.

During an interview on November 28, 2016, RPN #110 acknowledged that the "Side-Rail Use Assessment Form" had not been properly completed for resident #002. RPN #110 was unable to locate any additional documentation demonstrating that a full resident assessment had been completed with regards to the use of bed rails. As per the interview, RPN #110 had never completed a "Side-Rail Use Assessment Form" for any resident in the home.

On November 29, 2016, Inspector #211 observed that resident #003 was lying in bed with both bed rails in the up position. During an interview, ADOC #123 indicated to Inspector #211 that the "Side-Rail Use Assessment Form" was not completed for resident #003.

On the same day, DOC #100 confirmed that resident #002 was also not assessed for the use of bed rails before they were implemented. DOC #100 further acknowledged that no resident had been assessed for bed rails, unless they were considered to be restraining, prior to the initial implementation of the "Side-Rail Use Assessment Form" which had not been fully implemented to date due to the need for a bed system evaluation.

During an interview on December 1, 2016, DOC #100 explained that a "Side-Rail Use Assessment Form" had been provided to the home by their corporate office in late May or early June, 2016. DOC #100 explained that it was to be registered staff that completed the "Side-Rail Use Assessment Forms" in order to assess residents for bed rail use; and that the assessment could be completed in approximately 15-20 minutes. DOC #100 indicated that this "Side-Rail Use Assessment Form" was only temporarily implemented in July, 2016, prior to which time no resident was assessed specifically for the use of bed rails unless the rails were considered to be restraining.

During the interview on December 1, 2016, DOC #100 noted that at the top of the "Side-Rail Use Assessment Form", there is a space to identify if the bed system entrapment zones had been evaluated. DOC #100 explained to the Inspectors that when the "Side-Rail Use Assessment Form" was received by the home, none of the beds in the home with bed rails (bed systems) had been evaluated to ascertain if the potential zones of entrapment passed or failed the prescribed dimensional limit testing, as per the best practices guidance document from Health Canada, titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards". As a result, arrangements were made to have all bed systems evaluated; and, it was decided that the resident assessment forms would not be put into use until after that evaluation had occurred.

The bed system evaluation occurred on July 13th, 2016 and 70 out of 160 bed systems were given a failing grade, as one or more of the potential zones of entrapment failed the dimensional limit testing. DOC #100 explained that a

decision was made to officially halt the resident assessment process, until such time as corrective actions were taken and all bed systems with side rails were re-evaluated and given a passing grade.

DOC #100 indicated that registered staff felt uncomfortable speaking to the bed system evaluations when they had not done the testing themselves; and, also felt uncomfortable discussing the resident assessment with families where beds had not been evaluated or had been evaluated and had been given a failing grade. DOC #100 clarified that at that time, the resident "Side-Rail Use Assessment Forms" that had been done up to that time were pulled from the resident's files, and were not considered to be complete.

On December 1, 2016, DOC #100 confirmed that the assessment process for residents with bed rails in use was still on-hold.

On December 1, 2016, DOC #100 provided Inspectors #655 and #133 with a copy of the licensee's "Side-Rail Use Assessment Form". Inspectors #655 and #133 reviewed the licensees' "Side-Rail Use Assessment Form" at that time, and found that it was not fully in accordance with the current prevailing practices identified in "Clinical Guidance for the Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities and Home Care Settings" (U.S. FDA, 2003), a companion to the HC Guidance Document. The resident assessment did not address the residents' sleep patterns or habits nor did it take into account the sleep environment or the residents' level of comfort in bed. No clear documentation of a risk-benefit analysis was observed.

During an interview on the same day, DOC #100 also acknowledged that the licensee's bed rail use assessment process does not require that the sleeping patterns and habits of the resident are necessarily observed or assessed; and that the current assessment process is not of an interdisciplinary nature. DOC #100 further indicated that there is no process in place to trial clinical and environmental interventions as alternatives to bed rails before there is a decision to use bed rails. Rather, it was confirmed that all residents are admitted into bed systems with usable bed rails on them.

On December 1, 2016, DOC #100 provided Inspector #133 with all of the "Side Rail Use Assessment Forms" that had been completed when the assessment form had been temporarily implemented. It was determined that the assessment process had been completed for only 25 residents, 23 of whom were in the

home at the time of this inspection. Of those 25 assessment forms, only two were completed in full. The remaining assessment forms, including that belonging to resident #002, were incomplete in that they were missing information, such as no recommendation for the type of bed rail, no indication if the bed system entrapment zones had been checked, no indication of the rationale for bed rail use if it was recommended, or missing signatures.

Residents, including resident #002 and #003, were not assessed for the use of bed rails in accordance with prevailing practices to minimize risk to the resident.

In addition to providing guidance in establishing a clinical assessment where bed rails are used, the HC Guidance Document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools (the cone and cylinder tool) and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

As noted, all bed systems with bed rails on them in the home were evaluated in accordance with the methods outlined in the HC Guidance Document in July, 2016. The bed system evaluations were done by an outside service provider. The bed system evaluation document, provided to Inspector # 655 on November 28, 2016, by DOC #100 indicated that “if zones 1-4 pass entrapment testing a passing grade will be issued”. As well, a note on the document indicated “if any zones between 1-4 fails entrapment testing a failing grade will be issued”, and, “if zones 5,6 or 7 fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

As a result of the evaluation process, 70 out of 160 bed systems were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 1-4) exceeded the prescribed dimensional limits. The recommended solution for the 70 failed bed systems, from the outside service provider, was to replace the mattress with a specified brand and design of mattress.

During an interview with Maintenance Manager/Environmental Services Manager #131, DOC #100, and Administrator #132 on December 1, 2016, it was indicated to Inspectors #655 and #133 that modifications were made to four of

the 70 failed bed systems (#542, #552, #127, #227) following the bed system evaluations conducted in July, 2016. On all four of the noted bed systems, the bed rails were changed. In addition, the mattress was replaced on bed system #552.

At the same time, it was confirmed that following the changes made to the four noted bed systems, the resulting new bed systems had not been evaluated in accordance with the HC Guidance Document, including the testing of zones 1-4, in order to minimize risk to the residents.

On December 1, 2016, Inspectors #133 and #655 were informed of additional corrective actions that had been taken that day, to prevent resident entrapment, with regards to the bed systems that had been given a failing grade.

Administrator #132 informed the Inspectors that the mattresses had been replaced on seven of the 70 bed systems that had been given a failing grade (#350, #514, #513, #440, #450, #437a, and #452). According to Administrator #132, new mattresses put in place were of the specified brand and type recommended as the solution for bed systems that failed zone 2 exclusively. Only two of the seven bed systems which received a new mattress had failed zone 2 exclusively. The resulting seven new bed systems were not evaluated in accordance with the HC Guidance Document, including testing of zones 1-4, in order to minimize risk to the residents.

On December 2, 2016, through discussion with DOC #100 and review of documentation by Inspectors #133 and #655, it was established that since the July, 2016 bed evaluation process, a new bed system had been created in room #122. At the time of the evaluation process, the bed system that was in room #122 had been given a passing grade. In September, 2016, that bed system was relocated to another resident room; and, another bed system was moved into room #122. The bed system that was moved to room #122 had a specified type of mattress in place at the time of the bed evaluation process in July, 2016. DOC #100 informed the Inspector that the when this bed frame was moved into room #122, the mattress type changed. DOC #100 confirmed that the resulting new bed system in room #122 was not evaluated in accordance with the HC Guidance Document, including testing of zones 1-4, in order to minimize risk to the resident.

On December 2, 2016, DOC #100 explained to Inspector #133 that in July,

2016, the home had received a cone and cylinder tool, required for testing zones 1-4, but it had never been put into use. DOC#100 explained that the tool is shared with two of their sister homes, and that after approximately one month, the tool was sent to one of the other homes.

Over the course of the inspection, it was ascertained that where changes were made to a resident's bed system, such as a change of mattress or bed rails, the home did not have a process in place to ensure that the resulting new bed system was evaluated in accordance with evidence based practices, to minimize risk to the resident.

The licensee has failed to ensure that where bed rails are used, 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. [s. 15. (1) (a)]
(655)

2. The licensee has failed to ensure that where bed rails are used, steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

In August, 2012, the acting Director of the Performance Improvement and Compliance Branch, with the Ministry of Health and Long Term Care, issued a memo to all Long Term Care Home Administrators about the risk of bed-related entrapment. The memo directed that the Health Canada guidance document titled "Adult Hospital Beds: Patient Entrapment Hazards, Side Rail Latching Reliability, and Other Hazards" (HC guidance document) was to be used by all homes as a best practice document. The HC guidance document characterizes, where bed rails are used, the body parts at risk for life threatening entrapment (head, neck, chest), identifies the locations of hospital bed openings that are potential entrapment areas (Zones 1-7), recommends dimensional limits for the gaps in some of the potential entrapment areas (Zones 1-4), and prescribes test tools and methods to measure and assess gaps in some of the potential entrapment zones (Zones 1-4).

In July, 2016, all bed systems with bed rails on them in the home were evaluated in accordance with the methods outlined in the HC guidance document. The bed system evaluations were done by an outside service provider.

During an interview on November 28, 2016, DOC #100 provided Inspector #655 with the bed system evaluation document. The bed system evaluation document indicated that "if zones 1-4 pass entrapment testing a passing grade will be issued". As well, a note on the document indicated "if any zones between 1-4 fails entrapment testing a failing grade will be issued", and, "if zones 5,6 or 7 fails then a passing grade is issued but these zones should be addressed to ensure resident safety".

As a result of the evaluation process, 70 out of 160 bed systems (excluding bed systems with therapeutic air surfaces) were given a failing grade, as one or more of the potential zones of entrapment with prescribed dimensional limits (zones 2-4) exceeded the prescribed dimensional limits. There were no zone 1 failures. The recommended solution for the 70 failed bed systems, from the outside service provider, was to replace the mattress with a specified brand and design of mattress. Bed systems that failed in zone 2 exclusively were to have one specified design of mattress, and all other bed systems that failed were to have a second specified design of mattress. In the mattress notes column of the bed system evaluation document, it is reflected that 53 of the 70 mattresses on bed systems that were given a failing grade were in poor condition, while two were in fair condition (455B and 422A) and 16 were in good condition (542A, 111A, 149B, 240A, 437B, 527B, 549A, 522A, 142A, 153A, 209B, 249A, 437A, 543A, 426A, 452A).

For two of the 70 failed bed systems (#426A and #422A), zone 7 also failed. Zone 7 is the potential zone of entrapment (for the head) between the headboard or foot board and the mattress end, and is indicative of a mattress that does not fit the bed frame. Related to the bed system #426A, the recommended solution also included changing the bed. Related to the bed system #422A, the additional notes indicated "short mattress".

One bed system (#327A), that did not include a therapeutic air surface, was given a passing grade but was noted to have failed zone 7. The recommended solution was to replace the mattress with a specified brand and type of mattress, and the additional notes for the bed system (327A) indicated "short mattress".

Related to bed systems that include a therapeutic air surface, five were given a passing grade; however, zones 2, 3 and 4 failed the dimensional limit testing (109B, 126A,155A, 341A, 414A). These bed systems were given a passing grade because the HC guidance document exempts such therapeutic air

surfaces from the dimensional limit recommendations, except for the spaces within the perimeter of the rail (zone 1). The bed system evaluation document, in the solutions column, noted "LAL (partial exemption)" for these bed systems (LAL = low air loss). The HC document outlines (page 12 and 13) that this partial exemption is due to the highly compressible nature of these mattresses. As such, there is an inherent risk of entrapment in bed systems using these products with bed rails. Steps must be taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

During an interview on December 1, 2016, Inspectors #133 and #655 reviewed the outcomes of the July, 2016 bed system evaluation with Administrator #132, DOC #100, and Maintenance Manager/Environmental Services Manager #131. During the interview, it was confirmed to the Inspectors that with the exception of four bed systems (#542, #552, #127, #227), there had been no corrective actions or interventions implemented to date in relation to the failed potential zones of entrapment on the 76 identified bed systems (including the one bed system that was given a passing grade but failed zone 7; and the five bed systems with therapeutic air mattresses), to prevent resident entrapment. It was further confirmed that following changes made to the four noted bed systems, the resulting new bed systems had not been evaluated in accordance with the HC document, including testing of zones 1-4, as is required by O. Reg. 79/10, s. 15 (1) (a), in order to minimize risk to the residents. It was explained to the Inspectors that the home shares the cone and cylinder tool required to test zones 1-4 with two of their sister homes. The tool was received by the home in July, 2016, but it was not put into use before it was sent to one of the other homes. During the same interview, it was also confirmed that none of the residents in the bed systems with failed potential zones of entrapment had been assessed in accordance with evidence based practices or prevailing practices, as is required by O. Reg. 79/10, s. 15 (1) (a).

In the afternoon of December 1, 2016, Inspectors #133 and #655 were informed of corrective actions being taken to prevent resident entrapment with regards to the bed systems that had been given a failing grade. Administrator #132 informed the Inspectors that bed rails had been removed from 11 of the 70 bed systems that had been given a failing grade; and that the mattress had been replaced on seven of 70 bed systems that had been given a failing grade. The Administrator confirmed that the new mattresses put in place were of the specified brand and type recommended as the solution for bed systems that failed zone 2 exclusively. Only two of the seven bed systems which received a

new mattress had failed zone 2 exclusively. The resulting new bed systems were not evaluated in accordance with the HC document, including the testing of zones 1-4, in order to minimize risk to the residents.

Upon becoming aware that a total of 76 resident's bed systems with bed rails in use (including one bed system which passed but failed zone 7; and, the five identified bed systems with therapeutic air mattresses in place) were evaluated to have one or more failed potential zones of entrapment in July, 2016, the licensee did not take steps to prevent resident entrapment, taking into consideration the failed potential zones of entrapment.

As the non compliance described above is widespread, and presents the potential for actual harm to the residents, a compliance order will be served on the licensee. [s. 15. (1) (b)] (133)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 24, 2017

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 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 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 19th day of January, 2017

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Michelle Jones

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