Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Aug 25, 2020	2020_587129_0006	001848-20, 007742-20, 009224-20, 009882-20	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Hamilton
90 Chedmac Drive HAMILTON ON L9C 7S6

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): February 28, March 2, 4, 5, 6, 9, 10, 11, 12 ,13, (May 27, 28, June 2, 3, 4, 5, 8, 9, 10, 11, 15, 16, 17 as Off-Site inspection), June 18, 19, 22, 23, 24, (June 25, 26, July 6, 7, 8 as Off-Site inspection) , July 10, 13 and 14, 2020

The following intakes were inspected:
001848-20 related to falls management, nutrition and hydration, skin and wound management, medication administration, bowel management and environmental concerns related to temperature and humidity.
007742-20 related to quality of care, repositioning a resident, change of physician and essential visitor designation.
009224-20 related to monitoring a resident.
The following Critical Incident System intake #009882-20 related # 2858-000009-20 regarding monitoring of the resident has been inspected during this Complaint inspection as issues related to monitoring of the resident were also raised in a complaint intake.

During the course of the inspection, the inspector(s) spoke with residents, resident's family member, Personal Support Workers, Registered Practical Nurses, Recreation Therapist, Social Worker, Registered Dietitian, Manager of Support Services, Acting Director of Care, Administrator and Physicians.

During the course of this inspection the Inspector observed care provided to residents, reviewed clinical documentation and reviewed the licensee's policies and procedures.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

13 WN(s)
11 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with 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. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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 failed to ensure the care set out in the plan of care was provided to residents as specified in the plan.

a) Resident #001 was not provided with the care set out in their plan of care related to their nutrition and hydration care needs.

Data available at the time of this inspection confirmed that resident #001 had not received the amount of nutrition and hydration that their plan of care identified was required to meet the nutrition and hydration needs of the resident.

The Registered Dietitian (RD) assessed resident #001's daily nutrition and hydration needs and included specific directions in the plan of care in order to meet the resident's assessed needs.

At the time of this inspection the Acting Director of Care ((A) DOC) confirmed they had contacted the RD and verified their expectation related to resident #001's hydration care

requirements.

On a day in March 2020, the RD reassessed resident #001 and revised the plan of care related to both the nutrition and hydration care for the resident.

Two days after the RD had reassessed resident #001 and revised their plan of care, the Inspector and the (A) DOC reviewed available data that confirmed the resident had not been provided with the specific amounts of nutrition and hydration the RD had ordered them to receive. The data available at the time of this inspection was limited to the preceding 72-hour period.

The (A) DOC and the data available confirmed that resident #001 had not been provided with the care set out in their plan of care related to the provision of nutrition and hydration care as ordered by the RD.

b) Resident #006 was not provided with the care set out in their plan of care related to nutrition and hydration.

Data available at the time of this inspection confirmed that resident #006 had not received the amount of nutrition and hydration that the plan of care identified was required to meet the nutrition and hydration needs of the resident.

The Registered Dietitian (RD) assessed resident #006’s daily nutrition and hydration needs and included specific directions in the plan of care in order to meet the resident's assessed needs.

On a day in March 2020, the Inspector and the (A) DOC reviewed available data that confirmed the resident had not been provided with the specific amounts of nutrition and hydration the RD had ordered them to receive. The data available at the time of this inspection was limited to the preceding 72-hour period.

The (A) DOC and the data available confirmed that resident #006 had not been provided with the care set out in their plan of care related to the provision of nutrition and hydration care as ordered by the RD.

Resident #001 and resident #006 had not received the care set out in their plans of care related to the specific directions for meeting their nutrition and hydration needs. [s. 6. (7)]

2. The licensee failed to ensure that the provision of care set out in the plan of care was documented.

a) The provision of care set out in the plan of care for resident #001 related to checking and changing a wound dressing was not documented.

At the time of admission there were specific directions related to the management of a wound resident #001 had. The Physician ordered the dressing over the wound to be checked twice a day and the dressing was to be changed once a day. A review of the Treatment Administration Record (TAR) for the month of admission confirmed that these activities were to occur at 1000 hours and 2100 hours each day.

A review of the above noted TAR and progress notes made by registered staff, indicated that staff had not documented that the resident's wound dressing had been checked during the evening on one of 22 days.

A review of the following month's TAR and progress notes made by registered staff, indicated that staff had not documented that the resident's wound dressing had been checked during the evening on eight days.

A review of the following month's TAR and progress notes made by registered staff, indicated that staff had not documented that the resident's wound dressing had been checked during the evening on one of four days.

Following a review of the above noted clinical records, the (A) DOC acknowledged that staff had not documented the provision of care as set out above.

Staff failed to document the provision of care to resident #001, specifically that they had checked the wound dressing, as was set out in the resident's plan of care.

b) The provision of care set out in the plan of care for resident #001 related to their hydration needs was not documented.

Resident #001's plan of care included directions that they were to receive a specified amount of water before and after medication administration.

The March 2020 Medication Administration Record (MAR) indicated that for the first

eleven days of March the resident was to have received the specified amount of water when medications were administered at 0500 hours, 0800 hours, 0900 hours, 1700 hours, 2300 hours and when 19 as necessary medications were administered.

The March 2020 MAR confirmed that registered staff failed to document that the specified amount of water had been provided before and after medications administered at 0500 hours, 0900 hours, 2100 hours and when 19 as necessary medication were administered.

Registered staff did not document the provision of care set out in resident #001’s plan of care when they failed to document the provision of the specified amount of water administered before and after medication administration, as directed in the resident’s plan of care.

c) The provision of care set out in the plan of care for resident #006 related to their hydration needs was not documented.

The Registered Dietitian (RD) assessed resident #006’s daily hydration needs and developed a written plan of care to meet those needs. The plan of care specified the resident was to have their hydration needs met through the provision a specified amount of water before and after a procedure and before and after medication administration. Documentation of the provision of water was to be recorded on the resident's MAR.

Resident #006 was provided with a procedure two times each day. A review of the March 2020 MAR indicated staff had documented the provision of the specific amount of water before each of the twice daily procedures. The MAR indicated registered staff had not documented the provision of the specified amount of water at the conclusion of the twice daily procedures for the first 11 days of March 2020.

Resident #006’s 2020 March MAR indicated the resident received medications at 0800 hours, 1200 hours, 1600 hours, 1700 hours and 2000 hours daily. A review of this MAR confirmed that staff had documented that the resident received all the medications that had been ordered for them to receive; however, staff had not documented that the specific amount of water was provided to the resident before and after medication administration for the first 11 days of March 2020.

At the time of this inspection the (A) DOC reviewed the requirements for the

administration of water in the resident’s plan of care and following a review of the 2020 March MAR, they acknowledged that registered staff had not documented the provision of care related to the required provision of water after each of the twice daily procedure or before and after resident #006 was administered medication. [s. 6. (9) 1.]

3. The licensee failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised when the resident's care needs changed related to oral care.

Resident #001's oral care needs changed when observations made by the Inspector at the time of this inspection, as well as when physician's visiting the resident and staff documented on four occasions over a two-month period that there were significant issues with the appearance and condition of the resident's mouth.

Following a visit from the resident's physician, the physician ordered the resident to receive a specific treatment to improve the condition of their oral cavity which as to be provided four times daily. The care plan also provided specific directions for the provision of mouth care.

During a consult by a physician in March 2020, they documented in a consult note, that due to changes in the resident's condition they would no longer be able to perform their own oral care. At this time the plan of care that was in place, directed staff to have the resident provide their own oral care and staff were to complete the task from beginning to end if resident unable. There was no evidence in the clinical record that resident #001 had been reassessed related to the decline in their physical abilities and the ability to provide their own mouth care. A review of the plan of care that was in place at this time confirmed the plan had not been reviewed or revised to reflect the increase care assistance the resident required.

A month later, resident #001's physician documented in the clinical record, following a visit with the resident, that the nursing care plan was to reflect that the resident's mouth care/teeth brushing was to be done twice a day. The resident's plan of care was not revised for five days, with the directions to complete mouth care twice a day. A review of the plan of care in place at the time verified that the plan of care had not been reviewed or revised when it was noted the previous interventions that the resident be provided with supplies to complete their own mouth care had not been updated to reflect the change in the resident’s self care ability.

A month later registered staff documented a change in the condition of the residents

mouth. A review of the plan of care in place at this time confirmed that the plan of care had not been reviewed or revised when the resident demonstrated the above noted change in the condition of their mouth. When the resident's physician visited the resident a day later, they documented the condition of the resident's mouth and made a clinical note that directed the Registered Practical Nurse (RPN) to increase the quality/frequency of mouth care for the resident. A review of the plan of care in place at this time confirmed that the plan had not been reviewed or revised related to the physician's directions.

A consulting physician visited the resident two days later, observed the resident's mouth and noted the deterioration in the condition of the resident's mouth. A review of the plan of care in place at that the time confirmed that the resident's plan of care had not been reviewed or revised related to the observations of the condition of the resident's mouth, made by the physician.

During an interview with Personal Support Worker (PSW) #109, they confirmed they had regularly provided care to resident #001 and knew the care needs of the resident. When asked how they would describe the condition of the resident's mouth, they responded by explaining the deteriorating appearance of the resident's mouth.

The licensee failed to review and revise resident #001's plan of care, related to their oral/mouth care when it was identified that their care needs had changed and the condition of their oral cavity continued to deteriorate. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the “Order(s) of the Inspector”.
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 and ensuring that the provision of care set out in the plan of care is documented and residents are reassessed and the plan of care reviewed and revised when the resident's care needs change, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

In accordance with O. Reg. 79/10, s. 5 “neglect” means the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

a) Through a pattern of inaction, the licensee neglected to meet resident #001’s nutrition and hydration care needs when it was identified that the resident had not received nutrition and hydration care as ordered by the Registered Dietitian (RD).

Resident #001 required specialized nutrition and hydration care. The plan of care to meet the resident’s nutrition and hydration needs was developed following an assessment by the RD. The results of the RD’s assessment and their orders for care were identified in the resident’s plan of care.

The following pattern of inaction related to the provision of nutrition and hydration care identified during this inspection, jeopardized resident #001's health:

i) A family member of resident #001 identified to registered staff and the (A) DOC that they were concerned the resident had not been receiving the correct amount of nutrition and water. The (A) DOC acknowledged they were aware of the family members observations and concern that the resident had not been receiving the correct amount of nutrition and water. The (A) DOC acknowledged that they had taken no action to review the care that was provided to the resident in order to ensure the resident was receiving the care identified in their plan of care.

ii) Registered staff failed to act and clarify the order written by the RD related the nutritional care resident #001 was to receive. Resident #001’s plan of care directed that

the resident was scheduled for an activity that would prevent the resident from receiving nutritional care during the activity. Registered staff did not consult with the RD when on several occasions, observations made by registered staff would have provided evidence that resident #001 had not received the nutritional care the RD had ordered them to receive.

iii) Registered staff failed to act and clarify the order written by the RD related to the hydration care for resident #001. During a discussion with the (A) DOC they indicated that they did not have a clear understanding of the orders for the provision of water the RD had documented in the resident's plan of care. Following this discussion, the (A) DOC consulted with the RD who confirmed the directions in the plan of care were not consistent with the understanding of the (A) DOC and resident #001 required additional water in order to meet their hydration needs. The (A) DOC and data available at the time of this inspection confirmed that resident #001 had not received the hydration care the RD had identified to meet their hydration needs.

iv) During this inspection it was identified that staff failed to comply with the licensee's policy related to specialized nutrition and hydration care, identified as RC-18-01-09 and updated in December 2019 in relation to the care provided to resident #001.

Staff failed to comply with five specific directions contained in the above noted policy, when they provided care to resident #001.

During discussions with the (A) DOC they acknowledged that they had not taken action to ensure staff providing care to resident #001 reviewed the policy before providing care to the resident and no action was taken to monitor staff's compliance with the directions contained in the above noted policy.

v) It was identified through a review of the weight monitoring record in the computerized clinical record, that staff responsible for measuring resident #001's weight, did not take action to ensure they made accurate measurements. Weight measurements are a key component the RD used to determine the nutrition and hydration needs of resident #001.

The (A) DOC confirmed that resident #001 was reweighed multiple times and that they had completed some of the reweighs; however, they had taken no action to determine the cause of the inaccurate weights or to re-instruct staff on the correct method to weigh the resident. Resident #001 was weighed and reweighed three times over the first two

days of admission to the home and weighed and reweighed three times, less than two months later. The failure of staff to accurately weigh resident #001 and the lack of action to re-instruct staff who weighed resident #001, resulted in there being an unclear record of the resident's weight gain/weight loss, which jeopardized their health.

vi) Registered staff failed to act, and document hydration care ordered by the RD when they failed to document the provision of water before and after the administration of regularly scheduled and as necessary medications. This lack of action resulted in there being no evidence to demonstrate that resident #001 had received the amount of water the RD had identified as being required to meet the resident's hydration needs. This lack of action jeopardized the resident's health.

vii) Registered staff failed to act and document the amount of nutrition and water provided to resident #001 at the conclusion of an identified procedure. As a result, registered staff and the RD were not aware that the resident had not received the specified amount of nutrition and water that the RD had assessed as required to meet the nutritional and hydration needs of the resident. The Inspector and the (A) DOC accessed and reviewed data available that demonstrated resident #001 had not received the amount of nutrition and water the RD had assessed as required to meet the residents care needs. This failure to act jeopardized resident #001's health.

The above noted pattern of inaction related to the provision of nutrition and hydration care to resident #001, that included the lack of action taken when a family member identified a concern, the lack of action taken to clarify the RD's orders related to the resident's nutrition and hydration plan of care, the lack of action to ensure that the resident's weight was measured accurately, the lack of action to ensure that staff were aware of and complied with the licensee's policy and the lack of action taken by registered staff to ensure the provision of care was accurately documented in the clinical record, jeopardized resident #001's health when it was identified during this inspection that the resident had not received the nutrition and hydration care the RD had assessed as required.

b) Through a pattern of inaction, the licensee neglected to meet resident #006's nutrition and hydration care needs when it was identified that the resident had not received nutrition and hydration care as ordered by the Registered Dietitian (RD).

Resident #006 required specialized nutrition and hydration care. The plan of care to meet the resident's nutrition and hydration needs was developed following an assessment by

the Registered Dietitian (RD). The results of the RD’s assessment and their orders for care were identified in the resident’s plan of care.

The following pattern of inaction and lack of action related to the provision of nutrition and hydration care identified during this inspection jeopardized resident #006's health:

i) Registered staff failed to clarify the order written by the RD related the amount of nutrition the resident was to receive. During this inspection the Inspector and the (A) DOC accessed and reviewed available data that demonstrated resident #006 had not received the nutritional care identified by the RD as required to meet the nutritional needs of the resident.

ii) Registered staff failed to act and clarify the order written by the RD related to the amount of water resident #006 required to meet their hydration needs. A review of the above noted data with the (A) DOC, demonstrated that resident #006 had not received the amount of water required to meet their hydration needs.

iii) During this inspection it was identified that staff failed to comply with the licensee’s policy related to specialized nutrition and hydration care, identified as RC-18-01-09 and updated in December 2019, in relation to the care provided to resident #006.

Staff failed to comply with four specific directions contained in the above noted policy.

During discussions with the (A) DOC they acknowledged that they had not taken action to ensure staff providing care to resident #006 reviewed the policy before providing care the resident and no action was taken to monitor staff's compliance with the directions contained in the above noted policy.

iv) The lack of action by registered staff to document the provision of water before and after the administration of medications resulted in there being no evidence that the resident was administered the amount of water the RD had identified the resident required, which jeopardized the resident's hydration needs.

v) The lack of action by registered staff in documenting the nutrition and hydration care provided to resident #006 resulted in registered staff and the RD not being aware that resident #006 had not received the amount of nutrition and water the RD had determined the resident required and that was documented in the resident's plan of care. At the time of this inspection the Inspector and the (A) DOC accessed and reviewed available data

that demonstrated resident #006 had not received nutrition and hydration care identified by the RD. This failure to act jeopardized resident #001’s health.

The above noted pattern of inaction related to the provision of nutrition and hydration care to resident #006, that included; the lack of action taken to clarify the RD’s orders related to the resident’s nutrition and hydration plan of care, the lack of action to ensure that staff were aware of and complied with the licensee’s policy and the lack of action taken by registered staff to ensure the provision of care was accurately documented in the clinical record, jeopardized resident #006’s health when it was identified during this inspection that they had not received the nutrition and hydration care the RD had assessed as required.

c) Through a lack of action and a pattern of inaction the licensee neglected resident #001 when they failed to fully consider the scope and severity of resident #001's care and emotional needs and as a result repeatedly denied the resident the opportunity to have an essential visitor to provide care, emotional support and comfort.

Resident #001’s condition resulted in a rapid decline in their health status, including their functional abilities and an increase in safety concerns for the resident. Observations and interviews with the resident at the time of this inspection demonstrated that the resident had experienced several functional loses. During discussions with the (A) DOC they acknowledged that the resident’s health condition had deteriorated over the period of time since admission. The (A) DOC also confirmed that the resident’s Substitute Decision Maker (SDM) visited the resident regularly and advocated for the care of the resident.

A Physician specializing in the care for persons with the condition resident #001 experienced and who had consulted with the resident, documented in a consult note that the resident’s survival was likely measured in months.

When the Chief Medical Officer of Health (CMOH) announced in March 2020, that only persons identified as essential visitors could visit residents in long-term care homes, resident #001's SDM, who had previously voiced concerns about the care the resident had been receiving, requested that the home designate them as an essential visitor because the resident was both end-of-life and in need of critical care. It was noted that the CMOH's Directive #3 identified an essential visitor as someone visiting a very ill/palliative resident or a resident requiring end-of-life care.

The following lack of action and pattern of inaction resulted in resident #001 and their

SDM being repeatedly denied the opportunity to have additional support to meet their extensive physical and emotional care needs, which included; assistance related to communication, the provision of physical care as well as comfort and companionship while they were attempting to deal with a life ending medical diagnosis:

i) The (A) DOC did not take action, when they confirmed that they did not investigate or follow up with a request made by resident #001's SDM to hire a private care provider to provide care to the resident that they felt they home was not providing. The (A) DOC confirmed they had communicated to the SDM that "private care providers were against Ministry policy" and did not take action to clarify the use of private care providers in the home.

This lack of action resulted in resident #001 being denied the opportunity of to receive additional care and support that they and their SDM felt was required.

ii) The (A) DOC did not take action to fully review the CMOH's directions related to an essential care provider/visitor. The (A) DOC and clinical documentation confirmed that following the SDM's request to be designated as an essential care provider/visitor, they did not provide resident #001 with complete and accurate information related to visitor restrictions when they told the resident that the Ministry was not allowing visitors at this time to keep the resident's safe. Resident #001 cognition was intact, they were aware of their medical diagnosis and prognosis, had extreme difficulty communicating, as well as they were aware their health and functional status was rapidly declining.

This lack of action to provide complete and accurate information to the resident, resulted in the resident not having the opportunity to challenge the Administrator's decision to deny them having an essential care provider/visitor, which also resulted in the resident not receiving additional care and support.

iii) The Administrator acknowledged that they did not take action to develop or implement an objective process, guidelines or clinically appropriate definitions of the terms identified in the CMOH Directive #3 to guide them in making objective decisions when they received a request to designate an essential care provider/visitor for resident #001. The Administrator and the (A) DOC confirmed that resident #001's SMD repeatedly requested to be identified as an essential care provider/visitor as the resident's condition continued to deteriorate.

The lack of action in developing an objective process and guidelines resulted in resident

#001 and their SDM not being provided with justification for the Administrator's repeated denial to allow resident #001 to have an essential care provider/visitor. This also prevented the resident and their SDM from actively participating in the care planning process.

iv) The (A) DOC subsequently communicated to resident #001's SDM that they had applied the Palliative Performance Scale (PPS) assessment in order to determine that the resident was not eligible to have an essential care provider/visitor. At the time of this inspection a copy of a PPS assessment they indicated they had completed was provided.

This document indicated that when this clinically appropriate assessment tool was applied to resident #001, the resident was identified as being both very ill and, in the end-of-life stage. The (A) DOC confirmed that the PPS assessment was completed following the initial request by the resident's SDM and was only completed once.

The (A) DOC confirmed they did not take action to familiarize themselves with the PPS assessment and the implications of scored results. The (A) DOC acknowledged that they not completed many of this type of assessments and were unaware of the implications of the score resident #001 obtained.

The (A) DOC confirmed they did not communicate the purpose of the PPS assessment or the results of the assessment to resident #001 or their SDM.
The Administrator confirmed they did not take action to familiarize themselves with the PPS assessment, including the implications of scoring results. They also confirmed they had not reviewed the PPS assessment that had been completed by the (A) DOC prior to deciding that resident #001 did not meet the requirements identified in the above noted Directive #3 in order to be allowed an essential care provider/visitor.

The above noted lack of action related to the completed PSS assessment resulted in the resident and their SDM not being made aware that the resident had met the requirement to have an essential care provider/visitor, the resident not receiving the additional care and support that they felt was required to meet their physical and emotional care needs and resident #001 continuing to be denied the support of an essential care provider/visitor.

v) The Administrator and (A) DOC did not take action to involve clinical staff in the decision to deny an essential care provider/visitor for resident #001.

During an interview with the Administrator, they confirmed they had a meeting with resident #001's SDM and the (A) DOC; however, they did not speak with resident #001, their physician, or any other identified clinical staff member in making their decision.

During an interview with Registered Practical Nurse (RPN) #103 they identified themselves as the regular full time RPN on the home area where resident #001 resided. They confirmed they were not asked to, and did not participate, at any time, in a decision to allow resident #001 to have an essential care provider/visitor. During the above noted interview, they indicated that it was their feeling that the resident was deemed palliative on admission to the home because of their diagnosis. They also acknowledged that they were not aware that resident #001's SDM had repeatedly requested to be designated as an essential care provider/visitor. When asked if they felt resident #001 could have benefited from having an essential care provider/visitor, in response they provided two reasons why they thought resident #001 would have benefited by having an essential care provider/visitor.

During an interview with the Social Worker on June 24, 2020, they confirmed they had not participated in a decision to allow resident #001 to have an essential care provider/visitor.

The lack of action in ensuring the involvement of the clinical staff in the decision, resulted in a decision being made without the knowledge and expertise of the staff who regularly cared for the resident and understood the challenges in providing resident #001 with the care they required as well as the continued denial to allow resident #001 to have an essential care provider/visitor.

vi) The Administrator and the (A) DOC did not take action to ensure they reviewed clinical consult notes made by a consulting Physician who specialized in the care and treatment of persons with the same condition resident #001 experienced or a team of consulting Physicians who specialized in the provision of palliative care, prior to making ongoing decisions to deny resident #001 the support of an essential care provider/visitor. The above noted Physicians provided consultation services to resident #001.

Two consult notes made by the Physician who specialized in the treatment of persons with the same condition resident #001 experienced identified the rapid decline in the resident’s functional abilities and the likely course of resident #001 disease. These consult notes were available in the resident’s clinical record.

Four consult notes made by the team of Physicians who specialized in the provision of palliative care identified the rapid decline in the resident functional abilities, the negative impact visitor restrictions had on both the resident and their SDM, the trajectory of the resident’s illness, concerns about the home’s ability to provide the specific care resident #001 required as their disease progressed and the initiation of a process to have the resident transferred to another facility. These consult notes were available in the resident’s clinical record.

The above noted lack of action by the Administrator and (A) DOC in reviewing consult notes made by consulting Physicians, resulted in a lack of complete knowledge and understanding of resident #001's physical and emotional care needs and continued denials to allow resident #001 to have an essential care provider/visitor.

As a result of the above noted pattern of inaction the licensee neglected the care needs of resident #001 when they failed to consider the individual aspects of resident #001's care that needed to be provided on an urgent basis, the need for constant monitoring of the resident, their lack of functional ability to alert staff that they needed assistance, the increase in the need for more frequent provision of care as their condition continued to deteriorate and the need to be provided with emotional and grief support at the end of their life. This resulted in the ongoing denial by the Administrator to provide the resident with available additional support to meet their physical and emotional care needs.

d) The licensee neglected to provide care and services to resident #001 when they failed to perform required safety checks, care and ongoing monitoring of the resident over an extended period which jeopardized the resident’s health and safety.

As a result of resident #001’s deteriorating condition, they were unable to effectively communicate their needs, unable to perform any self care activities and unable to reposition themselves.

In response to previous concerns related the provision of care and monitoring of the resident, the SDM installed a camera in the resident's room. The camera was installed in such a way that it captured the resident and was activated when motion was detected in the room.

During an interview with the (A) DOC they acknowledged that resident #001's SDM had spoken to them about their concern that the resident was not being provided care and

not monitored for safety, on more than one occasion and they had not taken action to investigate and address this concern.

A review of documentation made by registered staff in the computerized clinical record indicated that the SDM regularly contacted them by telephone to alert staff to concerns and issues they identified when viewing camera footage.

The Regional Manager received an e-mail sent by resident #001's SDM, that was copied to the Administrator and the (A) DOC. The e-mail indicated that resident #001 had been constantly moaning, the SDM felt something was wrong, that the resident had not been checked on since 2033 hours the previous evening, that this was an ongoing concern that had been raised multiple times previously and noted the lack of checking the resident to be negligent.

The SDM provided a photographic, dated timeline of detected motion in the resident's room during the previous evening, night and early morning on the day they forwarded the above noted email. The timeline indicated that staff interacted with resident #001 when motion was detected at 2030 hours and the next time motion was detected in the resident's room was at 1028 hours the following day. This timeline indicated that no motion was detected (no one entered resident #001's room) to complete safety checks or to provide required care, between 2033 hours and 1028 the following day.

A record review of progress note entries made in the legal computerized clinical record by registered staff indicated that the Registered Nurse (RN) who worked during the evening, created a clinical note at 2215 hours that indicated they last interacted with resident #001 between 1820 hours and 2030 hours when they provided a treatment to the resident and made sure the monitor was turned on and working, because the SDM had called and asked them to make sure it was turned on. There were no progress note entries made by registered staff who worked the following shift between 2300 hours and 0700 hours to indicate staff had interacted with the resident during that period.

A review of entries made by registered staff in the legal computerized clinical record, specifically, the Medication Administration Record (MAR) and the Treatment Administration Record (TAR), during the evening shift (1500 hours to 2300 hrs) and the night shift (2300 hours to 0700 hours), for the above noted period were reviewed. Entries made by registered staff in the in the MAR and TAR could not be relied on to present an accurate timeline as it was noted that on several occasions medications and treatments were documented as provided hours after the medications and treatments were ordered

to be administered or provided, without corresponding documentation in the progress notes to identify why the plan of care had not been complied with.

A review of entries made by Personal Support Workers (PSW) in the legal computerized record indicated that in relation to the specific task to reposition resident #001 every two hours, no entries had been made related to provision of this care over a nine-hour period between 1458 hours and 0102 hours the next day. No further entries were made until 0609, which was a five-hour time period. Entries made by PSWs in the legal computerized record could not be relied on to present an accurate timeline as it was noted that staff had inserted the time care was provided in a time slot that was not the same as the time, they entered the information.

Following a review of clinical documentation, the (A) DOC acknowledged that registered staff did not consistently document events at the time they occur, did not demonstrate appropriate documentation of "late entry" records in the computerized record and documented the provision of care, often several hours after the care was ordered to be provided. They also acknowledged that it was the habit of PSW staff to not document care provided at the time the care was provided.

Resident #001 was neglected, when technological evidence identified that the resident was not provided with care or monitored for safety over a long period of time, which jeopardized this resident’s health, safety and well being [s. 19. (1)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents’ Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the right of every resident to not be neglected by the licensee or staff, was fully respected and promoted.

a) Resident #001's right to not be neglected by the licensee or staff was not fully respected and promoted, when during this inspection the following was identified:

i) As a result of a lack of action and a pattern of inaction by staff, resident #001's care needs related to the provision of nutrition and hydration care were neglected when it was identified that the resident had not been provided with nutrition and hydration care the Registered Dietitian (RD) had assessed as required to meet their care needs. This was confirmed following a review of data available at the time of this inspection.

The pattern of inaction that lead to the care neglect included: no action taken when the resident's SDM alerted staff that it appeared the resident was not receiving the nutrition and hydration care identified in the plan of care, inaction by registered staff when observations of the nutrition and hydration care provided did not meet the requirements in the resident's plan of care, inaction by registered staff to clarify the amount of water to be provided to the resident, inaction by registered staff to document the specific nutrition and hydration care provided to the resident, inaction by registered staff to accurately document the amount of water provided to the resident, inaction by registered staff to comply with the licensee's specialized nutrition and hydration policy, inaction by nursing leadership to ensure registered staff who provided care to the resident understood and complied with the licensee's policy, inaction by Personal Support Workers (PSW) to accurately measure the weight of resident #001 and the inaction of the (A) DOC to

address this issue when they became aware of it.

ii) Resident #001's care and emotional needs were neglected as a result of a lack of action and a pattern of inaction by nursing leadership and the Administrator to consider the scope and severity of resident #001's care and emotional needs before making a decision to deny the request for the resident to be allowed an essential care provider/visitor.

The pattern of inaction that lead to the neglect included: the lack of action by the (A) DOC to investigate and follow-up with a request by resident #001's SDM to hire a private care provider to provide additional care to the resident, the lack of action by the (A) DOC and the Administrator to fully review the directive from the Chief Medical Officer of Health related to visitor restriction, the lack of action by the Administrator to develop and implement an objective process by which to review requests related to essential visitors, the lack of action by the (A) DOC and the Administrator to familiarize themselves with the Palliative Performance Scale assessment tool and the implications for resident #001 related to the identified score, the lack of action by the (A) DOC and the Administrator to involve care staff and interdisciplinary team members in decisions related to the care of resident #001 and the lack of action taken to review clinical records and consultation notes prior to denying the request for resident #001 to have an essential care provider/visitor.

iii) Resident #001's care and safety needs were neglected when it was identified that the resident had not been checked for safety or had care provided over an extended period. This was identified as a result of a camera in the resident's room which detected motion in the room, captured a photograph of the motion and then created a timeline of staff entering the room.

b) Resident #006's right to not be neglected by the licensee or staff was not fully respected and promoted, when during this inspection the following was identified:

As a result of a lack of action and a pattern of inaction by staff, resident #006's care needs related to the provision of nutrition and hydration care were neglected. It was identified that the resident had not been provided with nutrition and hydration care the Registered Dietitian (RD) had assessed as required. This was confirmed following a review of data available at the time of this inspection.

The lack of action and the pattern of inaction that lead to the neglect included: inaction by

registered staff to ensure the resident received nutrition as ordered by the RD, inaction by registered staff to clarify the amount of water to be provided to the resident, inaction by registered staff to document the nutrition and hydration care provided to the resident, inaction by registered staff to accurately document the amount of water provided to the resident following the administration of medication, inaction by registered staff to comply with the licensee’s specialized nutrition policy, and the inaction by nursing leadership staff to ensure registered staff who provided care to the resident understood and complied with the licensee’s policy. [s. 3. (1) 3.]

2. The licensee failed to ensure that the right of every resident who is dying or who is very ill to have family and friends present 24 hours per day, was fully respected and promoted.

Resident #001, who had been diagnosed with an untreatable disease, was not afforded the right to have family present 24 hours a day.

During the inspection the Inspector observed and interviewed resident #001 and it was noted at that time, the resident experienced a decline in multiple functional abilities. It was noted that the resident’s cognitive abilities were intact.

During an interview with the (A) DOC, they indicated that the resident's condition and abilities had deteriorated over the past 38 days. They also indicated that the resident’s SDM visited the resident regularly, provided assistance to the resident and functioned as a liaison between the care providers and resident #001.

A consulting Physician who provided care to people with the same condition as resident #001 experienced, indicated in a consult note that the resident's condition was deteriorating as expected based on their diagnosis and the resident’s survival was likely to be measured in months.

On March 17, 2020, the Chief Medical Officer of Health directed that due to the provincial health emergency, only essential visitors should be permitted to enter long-term care homes. The directions defined essential visitors as those who have a resident who is very ill or requiring end-of-life care. Updates were subsequently made to the directions to include a person visiting a palliative resident and on May 21, 2020, the directive was updated to include family or volunteers providing care services and other health care services required to maintain good health.

On becoming aware of the visitor restrictions the resident's SDM requested that the home designate them as an essential care provider/visitor to allow them to provide additional care, assistance and comfort to the resident.

The (A) DOC acknowledged that in response to the above noted request from the SDM, they had applied the Palliative Performance Scale (PPS) assessment to resident #001 and the results indicated the resident was at the "end-of-life" stage.

The Administrator denied the request to allow resident #001 to have an essential care provider/visitor and the SDM was denied entry into the home to visit, care and comfort the resident.

The SDM made several more requests to be allowed to visit the resident as the resident's condition and functional abilities continued to deteriorate and all were denied.

Resident #001's medical diagnosis and the deterioration in their functional abilities resulted in the resident being considered very ill and dying and their right to have family and friends present in the home was not respected or promoted by the licensee. [s. 3. (1) 15.]

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 and ensuring that every residents right to not be neglected and every resident who is dying or very ill right to have family and friends present 24 hours per day are fully respected and promoted, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have institute or otherwise put in policy or procedure, that the policy or procedure was complied with.

In accordance with LTCHA 2007, c. 8, s., 11(1) and O. Reg. 79/10, s. 68(2) (a), the licensee is required to have an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents and an organized program of hydration for the home to meet the hydration needs of the residents. The organized programs include the development and implementation of policies and procedures related to nutritional care, dietary services and hydration.

a) The licensee failed to ensure staff complied with the licensee’s specialized nutrition policy, identified as RC-18-01-09, and updated in December 2019.

i) The above noted policy directed that when specialized nutrition and hydration care was provided, staff were directed to document the amount of nutrition and water provided daily to the resident.

Resident #001 and resident #006 were provided with specialized nutrition and hydration care.

The Registered Dietitian (RD) had assessed both resident #001 and resident #006, determined their nutritional and hydration needs and developed plans of care that would provide the required nutritional and hydration care.

At the time of this inspection the (A) DOC reviewed data available over the previous 72-

hour period and confirmed that resident #001 and resident #006 had not received the amount of nutrition the RD had identified as required to meet the residents nutritional and hydration needs.

The (A) DOC and a review of the clinical record confirmed that staff had not documented the amount of nutrition and water provided daily to resident #001, as was required according to the above noted policy.

The (A) DOC and a review of the clinical record confirmed that staff had not documented the amount of nutrition and water provided daily to resident #006, as was required according to the above noted policy.

Registered staff failed to comply with the above noted policy when they failed to document the amount of nutrition and water resident #001 and resident #006 were provided with and as a result staff and the RD were unaware that the two identified residents had not received the quantities of nutrition and water identified by the RD as required to meet their nutrition and hydration needs.

ii) The above noted policy directed:

-The specialized nutrition and hydration care order was to indicate how residents would receive the specialized care, times for the care to be provided, the type and quantity of the nutrition, maximum daily amounts of both nutrition and water, as well as the amount of additional water provided.

-Care plan must include specifically how the care would be provided.

-Progress notes must include information related to type of nutrition provided and the frequency of providing this care.

-Signage to be posted near the bedside to alert staff of an identified condition the resident may have and safety issues that must be in place when nutrition and hydration care was provided.

Resident #001’s, resident #006’s and resident #007’s received specialized nutrition and hydration care.

The licensee failed to ensure staff complied with the above noted policy when:

a) The specialized nutrition orders for resident #001, resident #006 and resident #007 did not contain the maximum daily volume of nutrition to be provided.

b) The care plan for resident #001, resident #006 and resident #007 did not include specific information about how the nutrition and hydration care would be provided.

c) Progress notes for resident #001 did not contain information related to the amount of nutrition provided.

d) No signage was observed to be posted near resident #001's or resident #006's bedside or in their rooms, to identify a specific condition for both residents or safety issued that must be in place when nutrition and hydration care was provided.

Registered staff failed to ensure that the licensee's policy related to the provision of specialized nutrition and hydration care was complied with as noted above for resident #001, resident #006 and resident #007.

b) The licensee failed to ensure that staff complied with the licensee's policy and associated procedures contained in the policy "Palliative Care Program", identified as RC-20-01-01, last updated December 2019 and located in the Resident Care Manual.

In accordance with LTCHA 2007, c. 8, s., 8(1), the licensee is to have an organized program of nursing services to meet the assessed needs of the residents.
In accordance with O. Reg. 79/10, s. 30(1) 1, every licensee shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act; there must be a written description of the program that includes relevant policies and procedures.

The above noted policy indicated that the licensee supported a comprehensive palliative approach to care designed to relieve suffering and improve the quality of life for residents and their families and that this approach begins when a resident has a progressive, life threatening or life limiting illness. Individual plans of care will be developed to address pain and symptom management, promote comfort and assist the resident with the psychological and spiritual challenges associated with end-of-life and facing one's own mortality.

The above noted policy included procedures that directed the following:

-The nurse is to implement a palliative approach to care with each new admission, conduct regular and ongoing assessments of the resident’s status and residents who would benefit from the implementation of palliative/end-of-life care strategies, as well as noted that Palliative Performance Scale scores can be used as an indicator.

-The interdisciplinary team are to develop and implement a Palliative Plan of Care with individual interventions.

Staff in the home failed to comply with the above noted policy when resident #001 was admitted to the home and a consulting Physician providing care to the resident documented that the resident’s life expectancy could be measure in months.

The clinical record, the Administrator, the (A) DOC and staff providing care to the resident confirmed that a palliative approach to care was not implemented on admission, as the above noted procedure directed and an individual plan of care was not developed to promote the comfort and assist with the psychological and spiritual issues as resident #001 faced their own mortality.

The (A) DOC confirmed that they completed a Palliative Performance Scale (PPS) assessment for resident #001, two months after the resident was admitted to the home. A review of the assessment indicated that resident #001 was considered at the end-of-life stage. The (A) DOC confirmed they did not complete further assessments related to the results of the PPS score or direct the interdisciplinary team to develop and implement a palliative plan of care for resident #001.

The (A) DOC confirmed that at the request of resident #001's SDM a referral was made to the Hamilton Palliative Outreach Team and the team completed four consults with the resident, their SDM and the (A) DOC over a 31-day period.

During an interview with staff #110, they confirmed that there used to be a Palliative Committee, they believed it was called "Pain and Palliative Committee", and this committee had not met in the last two years.

During an interview with the Social Worker, they confirmed that they had not had contact with resident #001 or participated in the development and implementation of an interdisciplinary palliative care plan for resident #001.

The licensee failed to ensure that staff providing care to resident #001 complied with the licensee's policy, identified above, when staff did not assess or develop and implement individual palliative plans of care, as was required in the policy and procedure. [s. 8. (1) (a), s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that where the Act or this Regulation requires the licensee of a long-term care home to have institute or otherwise put in policy or procedure, that the policy or procedure is complied with, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that when they received a written complaint concerning the care of a resident or the operation of the long-term care home, that the written complaint was immediately forwarded to the Director.

Resident #001's SDM submitted a written complaint via e-mail to the Regional Manager, with copies to the Administrator and (A) DOC on a day in May 2020. The written complaint alleged resident #001 had been neglected by staff and identified four areas of care related to the allegation.

The licensee submitted a Critical Incident Report (CIR) to the Director on the day the e-mail was received, that indicated a written allegation of neglect had been received from resident #001's SDM; however, the written complaint was not forwarded to the Director.

The Hamilton Service Area Office (HSAO) did not receive the written complaint and five days after the licensee and home received the above noted email, an e-mail was forwarded to the Administrator requesting the written complaint be provided to the Inspector.

During an interview with the Administrator, they acknowledged that they were aware of the requirement to submit written complaints to the Director and confirmed that they had not submitted the written complaint concerning the care for resident #001 to the Director. [s. 22. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring when the licensee receives a written complaint concerning the care of a resident or the operation of the long-term care home, that the written complaint is immediately forwarded to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee failed to report to the Director the results of every investigation undertaken under clause (1) (a), and every action under clause (1) (b).

On a day in May 2020, the licensee notified the Director, through the submission of a critical incident report , that the licensee received a written allegation of neglect related to resident #001.

During an interview with the Administrator, they indicated they had concluded their investigation into the allegation of abuse and found the allegation to be unfounded.

It was noted that the Critical Incident report had not been amended and the Administrator confirmed that they had not notified the Director of the results of their investigation or the actions taken in response to the incident. [s. 23. (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 and ensuring a report is sent to the Director of the results of every investigation undertaken under clause (1) (a), and every action under clause (1) (b), to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act, the Local Health System Integration Act, 2006 or the Connecting Care Act, 2019.

Findings/Faits saillants :

1. The licensee failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was reported immediately to the Director.

A Regional Director, the Administrator and the (A) DOC received an e-mail from resident #001's SDM that indicated the resident had been neglected by staff.

A Critical Incident Report (CIR), completed by the Administrator, indicated the Ministry of Long-Term Care's (MLTC) after hours pager had not been contacted with information related to this allegation of neglect.

Documentation entered into the Critical Incident System by the Administrator confirmed that the allegation was made via e-mail as well as the date and time the e-mail had been received by the above noted individuals.

Based on the circumstances related to the care of resident #001 and equipment in the resident’s room, the Administrator and (A) DOC had reasonable grounds to suspect that resident #001 had been neglected; however they did not immediately notified the Director of this allegation as evidenced by the CIR submission date and time being in excess of six hours after the start of the business day.

The Administrator acknowledged that they had not immediately notified the Director when they were made aware of the allegation that resident #001 had been neglected by staff. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that when a person who has reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident it is reported immediately to the Director, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
10. Health conditions, including allergies, pain, risk of falls and other special needs. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident’s plan of care was based on, at a minimum, interdisciplinary assessment of health conditions, including risk of falling.

Resident #001’s plan of care was not based on an assessment of the risk of falling.

Resident #001 was admitted in 2020, and on that day, staff identified the resident at high risk for falling based on the Morse Fall Risk Scale. The resident was identified at a high risk for falling because they had fallen in the past 30 days and the past 31 to 180 days, they used an assistive device to aid them when walking, they demonstrate an impaired gait and the resident had a medical condition that affected their mobility.

A review of the Falls Risk Assessment instrument that was initiated on the day of admission, indicated that registered staff had not implemented the assessment instrument the way it was intended to be implemented when they did not attempt to identify the root causes/trends of the previously identified falls, did not attempt to determine postural changes in the resident’s blood pressure when the resident was capable of standing with assistance and took no action to explain the extent of the

resident’s gait changes that were identified as impaired and unsteady. Registered staff who initiated this assessment instrument did not document accurate information when they indicated the resident did not have a secondary diagnosis. Admission information available to staff completing this instrument, indicated the resident had three diagnoses that could impact the risk for falling. Staff also failed to identify that the resident received a care intervention that also increased the risk for falling.

A review of the plan of care related to falls implemented on the day of admission and the day after admission, indicated there were two care interventions related to the use of the resident’s assistive device and a safety intervention, if the resident consented.

Resident #001 fell eight days after admission which resulted in an injury and fell the following day, which did not result in an injury.

During a discussion with the (A) DOC, they reviewed the “Falls Management - Falls Risk AX with Morse Score and Category” instrument that was initiated on the day of admission, and acknowledged the assessment instrument had not been implemented as it was intended to be implemented, contained inaccurate information and the plan of care developed following this assessment did not reflect the care resident #001 required related to their identified fall risk.

Resident #001’s plan of care was not based on an assessment of the risk for falling. [s. 26. (3) 10.]

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 and ensuring the plan of care is based on, at a minimum, an interdisciplinary assessment of health conditions, including risk of falling, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

a) During a discussion with resident #001, they indicated they had not received their scheduled bath on a day in February 2020.

A review of resident #001's plan of care indicated that resident #001 preferred a bath on Mondays during the day and Fridays during the evening. A review of documentation made by Personal Support Workers (PSW), verified that it had been documented that on the identified date "the bathing activity did not occur".

A review of progress notes made by registered staff on the identified date, did not indicate a reason resident #001 had not been provided with a bath at any time on the above noted date and there was no indication that a second bath had been scheduled.

Resident #001 and clinical documentation confirmed that the resident was not provided with their scheduled bath on the identified date, there was not a reason documented for why the scheduled bath was not provided and no indication the resident was provided with an alternative to the scheduled bath.

b) Clinical documentation made by PSW staff indicated resident #003 had a bath/shower on six days in February 2020.

The document reviewed indicated the resident did not have two scheduled baths or showers during the second and third weeks of February 2020.

A review of resident #003's plan of care indicated that resident #003 preferred a tub or shower on Mondays during the day and Thursdays during the day.

A review of progress notes made by registered staff during two specific two week periods in February 2020 did not indicate a reason resident #003 had not been provided with their scheduled bath/shower at any time during the above noted two weeks.

The (A) DOC and clinical documentation confirmed that the resident was not provided with two baths during the above noted two weeks in February 2020. [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident had fallen, the resident was assessed and were the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Resident #001 was not assessed using a clinically appropriate assessment instrument, when staff did not implement the designated assessment instrument the way it was intended to be implemented.

The licensee's "Falls Management Program", identified as RC-15-01-01, last updated in December 2019, directed that Post Fall Management included directions to hold a post fall huddle, ideally within the hour and complete a post fall assessment. The (A) DOC confirmed that the clinically appropriate post fall assessment instrument used in the home was the "Falls Management – Post Fall Assessment – V4" instrument, located in the computerized clinical record assessment library.

A review of the clinical record indicated that resident #001 fell on a day in 2020. Registered staff who attended the resident documented that the resident sustained an injury and the resident also indicated they had an identified reaction when they fell.

The computerized clinical record indicated that registered staff had initiated the Falls Management – Post Fall Assessment – V4 instrument, but had not completed the sections of the document related to the root cause analysis, how the fall could have been prevented, follow-up plan/or recommendations and did not identify they were making any referrals to interdisciplinary team members related to the first fall the resident experienced in the home.

During a discussion with the (A) DOC, they reviewed the above noted Post Fall Assessment instrument and confirmed that registered staff had not implemented the instrument the way it was intended to be implemented.

Registered staff did not assess Resident #001, using a clinically appropriate assessment instrument when it was confirmed that the clinically appropriate assessment instrument used by the home, was not implemented the way it was intended to be implemented. [s. 49. (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 and ensuring that when a resident had fallen, the resident is assessed and were the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) Resident #001 exhibited altered skin integrity at the time of their admission to the home.

The resident was not assessed using a clinically appropriate assessment instrument when registered staff did not implement the assessment instrument as it was intended to be implemented.

Observations documented in resident #001's clinical record confirmed the resident exhibited two areas of altered skin integrity.

The licensee's "Skin and Wound Program: Prevention of Skin Breakdown", identified as RC-23-01-01S, directed that staff were to perform a comprehensive head to toe assessment for all residents within 24 hours of admission, provided specific directions on how to perform this assessment and were directed to use the "Skin- Head to Toe Skin Assessment - V4" assessment instrument located in the computerized care system.

The above noted assessment instrument provided implementation directed to staff that included: Visually inspect all areas of the skin including extremities, bottom of feet, in between toes, palms of hands, in between fingers, trunk, ears and scalp. Visually inspect the finger nails and toe nails and include in the head to toe assessment an assessment the oral cavity, including inspection of mucous membranes inside the mouth for any sores, red areas or white spots.

Registered staff did not implement the Skin-Head to Toe Skin Assessment -V4, initiated on the day of admission as it was intended to be implemented, when they did not visually inspect resident #001's skin and identified on the assessment instrument that the resident had no areas of impaired skin integrity.

The (A) DOC and the clinical record confirmed that Resident #001 was not assessed using a clinically appropriate assessment instrument, when the two above noted areas of alteration in skin integrity were not identified and no further assessments of the areas were made.

b) Resident #005 was not assessed using a clinically appropriate assessment instrument when registered staff documented that the resident experienced one area of altered skin integrity.

On a date in 2019, registered staff documented in a progress note that a referral had been forwarded to the Wound Care Champion due to a new skin issue. The referral note made at the time indicated the resident exhibited an area of altered skin integrity. On the

same day, registered staff documented in a progress note that the resident had a area of altered skin integrity and documented the treatment provided related to this area.

Following a review of the clinical record, at the time of this inspection, the (A) DOC confirmed that a skin assessment had not been completed using the clinically appropriate instrument designated by the licensee, related to this area of altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was assessed by a registered dietitian who was a member of the staff of the home.

a) Upon admission to the home resident #001 exhibited two areas of altered skin integrity.

A review of progress notes for 31 days following the resident’s admission indicated the Registered Dietitian (RD) had documented clinical notes on four occasions during that period. The notes made by the RD addressed the nutritional and hydration needs of the resident; however, there was no indication that the resident had been assessed by the RD related to two identified areas of altered skin integrity during these visits.

During a discussion with the RD, they reviewed their clinical notes as well as referrals they had received and confirmed they had not received a referral to assess resident #001 related to altered skin integrity and they had not assessed the resident.

b) Registered staff identified that resident #005 exhibited altered skin integrity on a day in 2019 and forwarded a referral to the Wound Care Champion on the same day.

The clinical record indicated that a referral to the Registered Dietitian (RD) had not been completed related to the above noted area of altered skin integrity.

Following a review of the clinical record the (A)DOC confirmed that an assessment of the altered skin integrity resident #005 exhibited had not been completed by the RD. [s. 50. (2) (b) (iii)]

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

a) Upon admission to the home resident #001 exhibited two areas of altered skin integrity.

A review of the resident's plan of care indicated there was a focus, a goal and interventions developed for the above noted areas of altered skin integrity.

A review of the resident's Treatment Administration Records (TAR) indicated treatments had been provided to the two areas of altered skin integrity the resident exhibited.

During an interview with the (A) DOC they acknowledged that resident # 001 demonstrated the two areas of altered skin integrity.

Following a review of the clinical record the (A) DOC confirmed that staff had not completed weekly assessments for an identified period from the time of the resident's admission to the time of this inspection.

b) Resident #004 exhibited altered skin integrity and the area of altered skin was not reassessed at least weekly.

A review of the clinical record indicated that resident #004 exhibited two areas of altered skin integrity that were identified on a day in January 2020.

Registered staff completed an initial assessment using a "Skin-Weekly Impaired Skin Integrity Assessment - V4" document and a care plan focus was developed related to these alterations the following day.

A review of the January 2020 TAR indicated that treatment for the areas of altered skin integrity had been identified and treatments had been provided six times over a two-week period.

The (A) DOC and resident #004's clinical record confirmed that the above noted skin integrity issues were not reassessed at least weekly, over the above noted two-week period, as required.

c) Registered staff identified that resident #005 exhibited altered skin integrity on a day in December 2019.

A review of the of the 2020 January TAR indicated that a treatment had been ordered for the wound and staff documented the treatments had been provided twelve times over a 23-day period.

Following a review of the clinical record the (A) DOC confirmed that weekly reassessments had not been completed for the identify area of altered skin integrity over the above noted 23-day period, as required. [s. 50. (2) (b) (iv)]

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 and ensuring that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. The resident is assessed by a registered dietitian who is a member of the staff of the home and the resident is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Resident #001 did not have a drug administered to them in accordance with the directions for use prescribed by their physician.

On a day in February 2020, resident #001's physician ordered the resident to have a treatment ointment applied to an area of altered skin integrity, twice a day for two weeks. This direction was documented in the Treatment Administration Record (TAR). The ordered treatment ointment is considered a drug and had a Drug Identification Number (DIN).

A review of the Medication Administration Record (MAR), the Treatment Administration Record (TAR) and progress notes made in resident #001's clinical record, indicated that the resident was not administered this drug three times over the two-week period.

The (A) DOC reviewed the 2020 February TAR and acknowledged there was no evidence in the clinical record that the drug had been administered to the resident as identified above.

Resident #001 was not administered a drug in accordance with the directions prescribed by their physician. [s. 131. (2)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

s. 101. (3) The licensee shall ensure that,
(a) the documented record is reviewed and analyzed for trends at least quarterly; O. Reg. 79/10, s. 101 (3).
(b) the results of the review and analysis are taken into account in determining what improvements are required in the home; and O. Reg. 79/10, s. 101 (3).
(c) a written record is kept of each review and of the improvements made in response. O. Reg. 79/10, s. 101 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a response was made to resident #001's SDM that indicated what the licensee had done to resolve their complaint and that the licensee believed the complaint to be unfounded and the reasons for the belief.

Resident #001's SDM submitted a written complaint via e-mail to the Regional Manager, with copies to the Administrator and (A) DOC on a date in May 2020. This complaint

alleged the resident had been neglected by staff, as well as concerns about two other care areas for the resident.

During an interview with the (A) DOC they indicated that following the complaint, staff were provided with direction related to the provision of care to the resident.

During an interview with the Administrator they indicated that they had concluded that the allegations made in the complaint were unfounded.

During the above noted interviews with the Administrator and the (A) DOC they confirmed that the complainant was not provided with a response in relation to what actions were taken to resolve the complaint or the reason the licensee believed the complaint to be unfounded. [s. 101. (1) 3.]

2. The licensee failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint, (b) the date the complaint was received, (c) the type of action taken to resolve the complaint, including the date of the action, time frames for action to be taken and any follow-up action required, (d) the final resolution, if any, (e) every date on which any response was provided to the complainant and a description of the response and (f) any response made in turn by the complainant.

Resident #001's SDM submitted a written complaint via e-mail to the Regional Manager, with copies to the Administrator and (A) DOC. The written complaint alleged resident #001 had been neglected by staff, as well as concerns about two other areas of care for the resident.

During an interview with the Administrator and the (A) DOC at the time of this inspection, they reviewed the Complaint Log they had provided to the Inspector earlier in the day and verified that information about this complaint had not been entered the log.

During the above noted interview the Administrator and (A) DOC were asked if there was a record of this complaint in any other location, that complied with the requirements as read to them and they indicated there was not. [s. 101. (2)]

3. The licensee failed to ensure that documented record of the verbal or written complaints received by the home was reviewed and analyzed for trends at least quarterly.

During an interview with the Administrator and (A) DOC, the Administrator confirmed that the record of verbal and written complaints received since January 1, 2020, had not been reviewed or analyzed for trends. [s. 101. (3)]

Issued on this 21st day of September, 2020

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

Original report signed by the inspector.

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2020_587129_0006
Log No. / No de registre :	001848-20, 007742-20, 009224-20, 009882-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 25, 2020
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Hamilton 90 Chedmac Drive, HAMILTON, ON, L9C-7S6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pilar Henderson

To Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre : 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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).

Order / Ordre :

The licensee must be compliant with s.6 (7) of the LTCHA.

Specifically, the licensee must:

a) Ensure resident #001, resident #006, and any other residents, receive their identified nutrition and hydration as set out in the resident's plan of care.

b) Ensure that directions related to the provision of the identified nutrition and hydration set out in resident's plan of care are clear.

c) Ensure revisions to the plan of care related to specialized nutrition and hydration, are completed in consultation with the Registered Dietitian and or Director of Care.

Grounds / Motifs :

1. Resident #001 was not provided with the care set out in their plan of care related to their nutrition and hydration care needs.

Data available at the time of this inspection confirmed that resident #001 had not received the amount of nutrition and hydration that their plan of care identified was required to meet the nutritional needs of the resident.

The Registered Dietitian (RD) assessed resident #001's daily nutrition and hydration needs and included specific directions in the plan of care in order to meet the resident's assessed needs.

At the time of this inspection the Acting Director of Care ((A) DOC) confirmed

they had contacted the RD and verified their expectation related to resident #001's hydration care requirements.

On a day in March 2020, the RD reassessed resident #001 and revised the plan of care related to both nutrition and hydration care for the resident.

Two days after the RD had reassessed resident #001 and revised their plan of care, the Inspector and the (A) DOC reviewed available data that confirmed the resident had not been provided with the specific amounts of nutrition and hydration the RD had ordered them to receive. The data available at the time of this inspection was limited to the preceding 72-hour period.

The (A) DOC and the data available confirmed that resident #001 had not been provided with the care set out in their plan of care related to the provision of nutrition and hydration care as ordered by the RD.

(129)

2. Resident #006 was not provided with the care set out in their plan of care related to nutrition and hydration.

Data available at the time of this inspection confirmed that resident #006 had not received the amount of nutrition and hydration that the plan of care identified was required to meet the nutrition and hydration needs of the resident.

The Registered Dietitian (RD) assessed resident #006's daily nutrition and hydration needs and included specific directions in the plan of care in order to meet the resident's assessed needs.

On a day in March 2020, the Inspector and the (A) DOC reviewed available data that confirmed the resident had not been provided with the specific amounts of nutrition and hydration the RD had ordered them to receive. The data available at the time of this inspection was limited to the preceding 72-hour period.

The (A) DOC and the data available confirmed that resident #006 had not been provided with the care set out in their plan of care related to the provision of nutrition and hydration care as ordered by the RD.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 18, 2020

Order # / No d'ordre : 002 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s.19(1) of the LTCHA

Specifically, the licensee must:

1. Ensure resident #001, resident #006 and any other residents are not neglected.

2. Training is to be provided as specified below to all registered staff and Personal Support Workers (PSW) who are employees of the licensee. All staff specified below who did not continue working in the home as their primary work location under Directive #3 for the Long-Term Care Homes Act 2007 issued March 22, 2020, will receive the training identified below, when they return to work in the home. The licensee is to retain documented evidence of the specific content of training provided as well as attendance records of staff participating in the following face to face training:

a) For all identified staff who provided care to resident #001 and resident #006 over an identified period of time, training on the licensee's policy related to the Prevention of Abuse and Neglect. This training is to include examples of what type of actions or inaction constitutes neglect in the provision of care to residents.

b) For all identified registered staff who provided care to resident #001 and resident #006, over an identified period of time, training on the licensee's policy for the provision of specialized nutrition and hydration care. This training is to include training on the features and operation of identified nutritional aides used by resident #001, resident #006 and any other resident.

c) For all identified staff who provided care to resident #001 over an identified period of time, training on the licensee's policies related to the provision of palliative care. This training is to include clear definitions of the terms; "end-of-life", "very ill" and "palliative". This training is also to include specific training for the identified registered staff on the application and scoring implications for the Palliative Performance Scale (PPS), the End-stage Disease Sign and Symptom Scale (CHESS) and any other tools used in the home related to palliation.

d) For all identified Personal Support Workers (PSW) who were responsible for measuring resident #001's weight over an identified period of time, training related to the weighing of residents. This training is to include training related to the types of scales that are used on an identified home area as well as resident situations that may pose a challenge with respect to obtaining accurate resident weights.

e) For all identified staff who documented care for resident #001 and resident #006 over an identified period of time, training related to the licensee's expectation as well as the expectation from any appropriate regulatory body, for documenting care in the legal clinical record. This training is to include; demonstration of documentation tools used and examples of appropriate documentation practices for PSWs as well as documentation tools used and examples of appropriate documentation by registered staff.

3. Develop and implement an auditing process and schedule to regularly audit the actual care residents who reside on an identified home area receive. The licensee is to maintain a copy of the audit tools used and audit results.

Grounds / Motifs :

1. Registered staff failed to ensure that resident #001 was not neglected related to the provision of care to meet their nutrition and hydration needs.

Through a pattern of inaction, the licensee neglected to meet resident #001's nutrition and hydration care needs when it was identified that the resident had not received nutrition and hydration care as ordered by the Registered Dietitian (RD).

Resident #001 required specialized nutrition and hydration care. The plan of care to meet the resident's nutrition and hydration needs was developed following an assessment by the RD. The results of the RD's assessment and their orders for care were identified in the resident's plan of care.

The following pattern of inaction related to the provision of nutrition and hydration care identified during this inspection, jeopardized resident #001's health:

i) A family member of resident #001 identified to registered staff and the (A) DOC that they were concerned the resident had not been receiving the correct amount of nutrition and water. The (A) DOC acknowledged they were aware of the family members observations and concern that the resident had not been receiving the correct amount of nutrition and water.

The (A) DOC acknowledged that they had taken no action to review the care that was provided to the resident in order to ensure the resident was receiving the care identified in their plan of care.

ii) Registered staff failed to act and clarify the order written by the RD related the nutritional care resident #001 was to receive. Resident #001's plan of care directed that the resident was scheduled for an activity that would prevent the resident from receiving nutritional care during the activity. Registered staff did not consult with the RD when on several occasions, observations made by registered staff would have provided evidence that resident #001 had not received the nutritional care the RD had ordered them to receive to meet their nutritional needs.

iii) Registered staff failed to act and clarify the order written by the RD related to the hydration care for resident #001. During a discussion with the (A) DOC they indicated that they did not have a clear understanding of the orders for the provision of water the RD had documented in the resident's plan of care. Following this discussion, the (A) DOC consulted with the RD who confirmed the directions in the plan of care were not consistent with the understanding of the (A) DOC and resident #001 required additional water in order to meet their hydration needs.

The (A) DOC and data available at the time of this inspection confirmed that resident #001 had not received the hydration care the RD had identified to meet their hydration needs.

iv) During this inspection it was identified that staff failed to comply with the licensee's policy related to specialized nutrition and hydration care, identified as RC-18-01-09 and updated in December 2019 in relation to the care provided to resident #001.

Staff failed to comply with five specific directions contained in the above noted policy, when they provided care to resident #001.

During discussions with the (A) DOC they acknowledged that they had not taken action to ensure staff providing care to resident #001 reviewed the policy before providing care to the resident and no action was taken to monitor staff's compliance with the directions contained in the above noted policy.

v) It was identified through a review of the weight monitoring record in the computerized clinical record, that staff responsible for measuring resident #001's weight, did not take action to ensure they made accurate measurements. Weight measurements are a key component the RD used to determine the nutrition and hydration needs of resident #001.

The (A) DOC confirmed that resident #001 was reweighed multiple times and that they had completed some of the reweighs; however, they had taken no action to determine the cause of the inaccurate weights or to re-instruct staff on the correct method to weigh the resident. Resident #001 was weighed and reweighed three times over the first two days of admission to the home and weighed and reweighed three times, less than two months later.

The failure of staff to accurately weigh resident #001 and the lack of action to re-instruct staff who weighed resident #001, resulted in there being an unclear record of the resident's weight gain/weight loss, which jeopardized their health.

vi) Registered staff failed to act and document hydration care ordered by the RD when they failed to document the provision of water before and after the administration of regularly scheduled and as necessary medications.

This lack of action resulted in there being no evidence to demonstrate that resident #001 had received the amount of water the RD had identified as being required to meet the resident's hydration needs. This lack of action jeopardized the resident's health and hydration needs.

vii) Registered staff failed to act and document the amount of nutrition and water provided to resident #001 at the conclusion of an identified procedure.

As a result, registered staff and the RD were not aware that the resident had not received the specified amount of nutrition and water that the RD had assessed as required to meet the nutritional and hydration needs of the resident.

The Inspector and the (A) DOC accessed and reviewed data available that demonstrated resident #001 had not received the amount of nutrition and water the RD had assessed as required to meet the residents care needs. This failure to act jeopardized resident #001's health.

The above noted pattern of inaction related to the provision of nutrition and hydration care to resident #001, that included the lack of action taken when a family member identified a concern, the lack of action taken to clarify the RD's orders related to the resident's nutrition and hydration plan of care, the lack of action to ensure that the resident's weight was measured accurately, the lack of action to ensure that staff were aware of and complied with the licensee's policy and the lack of action taken by registered staff to ensure the provision of care was accurately documented in the clinical record, jeopardized resident #001's health when it was identified during this inspection that the resident had not received the nutrition and hydration care the RD had assessed as required.

2. Registered staff failed to ensure that resident #006 was not neglected related to the provision of care to meet their nutrition and hydration needs.

Through a pattern of inaction, the licensee neglected to meet resident #006's nutrition and hydration care needs when it was identified that the resident had not received nutrition and hydration care as ordered by the Registered Dietitian (RD).

Resident #006 required specialized nutrition and hydration care. The plan of care to meet the resident's nutrition and hydration needs was developed following an assessment by the Registered Dietitian (RD). The results of the RD's assessment and their orders for care were identified in the resident's plan of care.

The following pattern of inaction and lack of action related to the provision of nutrition and hydration care identified during this inspection jeopardized resident #006's health:

i) Registered staff failed to clarify the order written by the RD related the amount of nutrition the resident was to receive.

During this inspection the Inspector and the (A) DOC accessed and reviewed available data that demonstrated resident #006 had not received the nutritional care identified by the RD as required to meet the nutritional needs of the resident.

ii) Registered staff failed to act and clarify the order written by the RD related to the amount of water resident #006 required to meet their hydration needs.

A review of the above noted data with the (A) DOC, demonstrated that resident #006 had not received the amount of water required to meet their hydration needs.

iii) During this inspection it was identified that staff failed to comply with the licensee's policy related to specialized nutrition and hydration care, identified as RC-18-01-09 and updated in December 2019, in relation to the care provided to resident #006.

Staff failed to comply with four specific directions contained in the above noted policy.

During discussions with the (A) DOC they acknowledged that they had not taken action to ensure staff providing care to resident #006 reviewed the policy before providing care the resident and no action was taken to monitor staff's compliance with the directions contained in the above noted policy.

iv) The lack of action by registered staff to document the provision of water before and after the administration of medications resulted in there being no evidence that the resident was administered the amount of water the RD had identified the resident required, which jeopardized the resident's hydration needs.

v) The lack of action by registered staff in documenting the nutrition and hydration care provided to resident #006 resulted in registered staff and the RD not being aware that resident #006 had not received the amount of nutrition and water the RD had determined the resident required and that was documented in the resident's plan of care.

At the time of this inspection the Inspector and the (A) DOC accessed and reviewed available data that demonstrated resident #006 had not received nutrition and hydration care identified by the RD. This failure to act jeopardized resident #001's health.

The above noted pattern of inaction related to the provision of nutrition and hydration care to resident #006, that included; the lack of action taken to clarify the RD's orders related to the resident's nutrition and hydration plan of care, the lack of action to ensure that staff were aware of and complied with the licensee's policy and the lack of action taken by registered staff to ensure the provision of care was accurately documented in the clinical record, jeopardized resident #006's health when it was identified during this inspection that they had not received the nutrition and hydration care the RD had assessed as required.

3.The Administrator and nursing leadership staff failed to ensure resident #001's care and emotional needs were not neglected.

Through a lack of action and a pattern of inaction the licensee neglected resident #001 when they failed to fully consider the scope and severity of resident #001's care and emotional needs and as a result repeatedly denied the resident the opportunity to have an essential visitor to provide care, emotional support and comfort.

Resident #001's condition resulted in a decline in their health status, including

their functional abilities and an increase in safety concerns for the resident. Observations and interviews with the resident at the time of this inspection demonstrated that the resident had experienced several functional loses. During discussions with the (A) DOC they acknowledged that the resident's health condition had deteriorated over the period of time since admission. The (A) DOC also confirmed that the resident's Substitute Decision Maker (SDM) visited the resident regularly and advocated for the care of the resident.

A Physician specializing in the care for persons with the condition resident #001 experienced and who had consulted with the resident documented in a consult note that the resident's survival was likely measured in months.

When the Chief Medical Officer of Health (CMOH) announced in March 2020, that only persons identified as essential visitors could visit residents in long-term care homes, resident #001's SDM, who had previously voiced concerns about the care the resident had been receiving, requested that the home designate them as an essential visitor because the resident was both end-of-life and in need of critical care. It was noted that the CMOH's Directive #3 identified an essential visitor as someone visiting a very ill/palliative resident or a resident requiring end-of-life care.

The following lack of action and pattern of inaction resulted in resident #001 and their SDM being repeatedly denied the opportunity to have additional support to meet their extensive physical and emotional care needs, which included; assistance related to communication, the provision of physical care as well as comfort and companionship while they were attempting to deal with a life ending medical diagnosis.

i) The (A) DOC did not take action, when they confirmed that they did not investigate or follow up with a request made by resident #001's SDM to hire a private care provider to provide care to the resident that they felt they home was not providing. The (A) DOC confirmed they had communicated to the SDM that "private care providers were against Ministry policy" and did not take action to clarify the use of private care providers in the home.

This lack of action resulted in resident #001 being denied the opportunity of to receive additional care and support that they and their SDM felt was required.

ii) The (A) DOC did not take action to fully review the CMOH's directions related to an essential care provider/visitor. The (A) DOC and clinical documentation confirmed that following the SDM's request to be designated as an essential care provider/visitor, they did not provide resident #001 with complete and accurate information related to visitor restrictions when they told the resident that the Ministry was not allowing visitors at this time to keep the resident's safe. Resident #001 cognition was intact, they were aware of their medical diagnosis and prognosis, had difficulty communicating, as well as they were aware their health and functional status was declining.

This lack of action to provide complete and accurate information to the resident, resulted in the resident not having the opportunity to challenge the Administrator's decision to deny them having an essential care provider/visitor, which also resulted in the resident not receiving additional care and support.

iii) The Administrator acknowledged that they did not take action to develop or implement an objective process, guidelines or clinically appropriate definitions of the terms identified in the CMOH Directive #3 to guide them in making objective decisions when they received a request to designate an essential care provider/visitor for resident #001. The Administrator and the (A) DOC confirmed that resident #001's SMD repeatedly requested to be identified as an essential care provider/visitor as the resident's condition continued to deteriorate.

The lack of action in developing an objective process and guidelines resulted in resident #001 and their SDM not being provided with justification for the Administrator's repeated denial to allow resident #001 to have an essential care provider/visitor. This also prevented the resident and their SDM from actively participating in the care planning process.

iv) The (A) DOC subsequently communicated to resident #001's SDM that they had applied the Palliative Performance Scale (PPS) assessment in order to determine that the resident was not eligible to have an essential care provider/visitor. At the time of this inspection a copy of a PPS assessment they indicated they had completed was provided.

This document indicated that when this clinically appropriate assessment tool

was applied to resident #001, the resident was identified as being both very ill and, in the end-of-life stage. The (A) DOC confirmed that the PPS assessment was completed following the initial request by the resident's SDM and was only completed once.

The (A) DOC confirmed they did not take action to familiarize themselves with the PPS assessment and the implications of scored results. The (A) DOC acknowledged that they not completed many of this type of assessments and were unaware of the implications of the score resident #001 obtained.

The (A) DOC confirmed they did not communicate the purpose of the PPS assessment or the results of the assessment to resident #001 or their SDM.

The Administrator confirmed they did not take action to familiarize themselves with the PPS assessment, including the implications of scoring results. They also confirmed they had not reviewed the PPS assessment that had been completed by the (A) DOC prior to deciding that resident #001 did not meet the requirements identified in the above noted Directive #3 in order to be allowed an essential care provider/visitor.

The above noted lack of action related to the completed PSS assessment resulted in the resident and their SDM not being made aware that the resident had met the requirement to have an essential care provider/visitor, the resident not receiving the additional care and support that they felt was required to meet their physical and emotional care needs and resident #001 continuing to be denied the support of an essential care provider/visitor.

v) The Administrator and (A) DOC did not take action to involve clinical staff in the decision to deny an essential care provider/visitor for resident #001.

During an interview with the Administrator, they confirmed they had a meeting with resident #001's SDM and the (A) DOC; however, they did not speak with resident #001, their physician, or any other identified clinical staff member in making their decision.

During an interview with Registered Practical Nurse (RPN) #103 they identified themselves as the regular full time RPN on the home area where resident #001

resided. They confirmed they were not asked to, and did not participate, at any time, in a decision to allow resident #001 to have an essential care provider/visitor. During the above noted interview, they indicated that it was their feeling that the resident was deemed palliative on admission to the home because of their diagnosis. They also acknowledged that they were not aware that resident #001's SDM had repeatedly requested to be designated as an essential care provider/visitor. When asked if they felt resident #001 could have benefited from having an essential care provider/visitor, they provided two reasons why they thought resident #001 would have benefited by having an essential care provider/visitor.

During an interview with the Social Worker on June 24, 2020, they confirmed they had not participated in a decision to allow resident #001 to have an essential care provider/visitor.

The lack of action in ensuring the involvement of the clinical staff in the decision, resulted in a decision being made without the knowledge and expertise of the staff who regularly cared for the resident and understood the challenges in providing resident #001 with the care they required as well as the continued denial to allow resident #001 to have an essential care provider/visitor.

vi) The Administrator and the (A) DOC did not take action to ensure they reviewed clinical consult notes made by a consulting Physician who specialized in the care and treatment of persons with the same condition resident #001 experienced or a team of consulting Physicians who specialized in the provision of palliative care, prior to making ongoing decisions to deny resident #001 the support of an essential care provider/visitor. The above noted Physicians provided consultation services to resident #001.

Two consult notes made by the Physician who specialized in the treatment of persons with the same condition resident #001 experienced identified the rapid decline in the resident's functional abilities and the likely course of resident #001 disease. These consult notes were available in the resident's clinical record.

Four consult notes made by the team of Physicians who specialized in the provision of palliative care identified the rapid decline in the resident functional abilities, the negative impact visitor restrictions had on both the resident and

their SDM, the trajectory of the resident's illness, concerns about the home's ability to provide the specific care resident #001 required as their disease progressed and the initiation of a process to have the resident transferred to another facility. These consult notes were available in the resident's clinical record.

The above noted lack of action by the Administrator and (A) DOC in reviewing consult notes made by consulting Physicians, resulted in a lack of complete knowledge and understanding of resident #001's physical and emotional care needs and continued denials to allow resident #001 to have an essential care provider/visitor.

As a result of the above noted pattern of inaction the licensee neglected the care needs of resident #001 when they failed to consider the individual aspects of resident #001's care that needed to be provided on an urgent basis, the need for constant monitoring of the resident, their lack of functional ability to alert staff that they needed assistance, the increase in the need for more frequent provision of care as their condition continued to deteriorate and the need to be provided with emotional and grief support at the end of their life. This resulted in the ongoing denial by the Administrator to provide the resident with available additional support to meet their physical and emotional care needs.

4. Registered staff and Personal Support Workers failed to ensure that resident #001's care and safety needs were not neglected when they failed to perform required safety checks, care and ongoing monitoring of the resident over an extended period which jeopardized the resident's health and safety.

As a result of resident #001's deteriorating condition, they were unable to effectively communicate their needs, unable to perform any self care activities and unable to reposition themselves.

In response to previous concerns related the provision of care and monitoring of the resident, the SDM installed a camera in the resident's room. The camera was installed in such a way that it captured the resident and was activated when motion was detected in the room.

During an interview with the (A) DOC they acknowledged that resident #001's

SDM had spoken to them about their concern that the resident was not being provided care and not monitored for safety, on more than one occasion and they had not taken action to investigate and address this concern.

A review of documentation made by registered staff in the computerized clinical record indicated that the SDM regularly contacted them by telephone to alert staff to concerns and issues they identified when viewing camera footage.

The Regional Manager received an e-mail sent by resident #001's SDM, that was copied to the Administrator and the (A) DOC. The e-mail indicated that resident #001 had been constantly moaning, the SDM felt something was wrong, that the resident had not been checked on since 2033 hours the previous evening, that this was an ongoing concern that had been raised multiple times previously and noted the lack of checking the resident to be negligent.

The SDM provided a photographic, dated timeline of detected motion in the resident's room during the previous evening, night and early morning on the day they forwarded the above noted email. The timeline indicated that staff interacted with resident #001 when motion was detected at 2030 hours and the next time motion was detected in the resident's room was at 1028 hours the following day. This timeline indicated that no motion was detected (no one entered resident #001's room) to complete safety checks or to provide required care, between 2033 hours and 1028 the following day.

A record review of progress note entries made in the legal computerized clinical record by registered staff indicated that the Registered Nurse (RN) who worked during the evening, created a clinical note at 2215 hours that indicated they last interacted with resident #001 between 1820 hours and 2030 hours when they provided a treatment to the resident and made sure the monitor was turned on and working, because the SDM had called and asked them to make sure it was turned on. There were no progress notes entries made by registered staff who worked the following shift between 2300 hours and 0700 hours to indicate staff had interacted with the resident during that period.

A review of entries made by registered staff in the legal computerized clinical record, specifically, the Medication Administration Record (MAR) and the Treatment Administration Record (TAR), during the evening shift (1500 hours to

2300 hrs) and the night shift (2300 hours to 0700 hours), for the above noted period were reviewed. Entries made by registered staff in the in the MAR and TAR could not be relied on to present an accurate timeline as it was noted that on several occasions medications and treatments were documented as provided hours after the medications and treatments were ordered to be administered or provided, without corresponding documentation in the progress notes to identify why the plan of care had not been complied with.

A review of entries made by Personal Support Workers (PSW) in the legal computerized record indicated that in relation to the specific task to reposition resident #001 every two hours, no entries had been made related to provision of this care over a nine-hour period between 1458 hours and 0102 hours the next day. No further entries were made until 0609, which was a five-hour time period. Entries made by PSWs in the legal computerized record could not be relied on to present an accurate timeline as it was noted that staff had inserted the time care was provided in a time slot that was not the same as the time, they entered the information.

Following a review of clinical documentation, the (A) DOC acknowledged that registered staff did not consistently document events at the time they occur, did not demonstrate appropriate documentation of "late entry" records in the computerized record and documented the provision of care, often several hours after the care was ordered to be provided. They also acknowledged that it was the habit of PSW staff to not document care provided at the time the care was provided.

Resident #001 was neglected, when technological evidence identified that the resident was not provided with care or monitored for safety over a long period of time, which jeopardized this resident’s health, safety and well being [s. 19. (1)]

5. The severity of this issue was determined to be a level 3 as there was actual risk of harm to the residents. The scope of the issue was determined to be a level 2 as it related to two of three residents reviewed. The home had a level 2 compliance history as they had one or more non-compliance, none of which were the same subsection being cited.
-Additionally the licensee has been issued 2 unrelated Compliance orders over

the past 36 months.

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 18, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 25th day of August, 2020

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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