Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Aug 14, 2019	2019_633577_0010 (A1)	001759-19, 004010-19, 004242-19, 007000-19, 009356-19	Complaint

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street THUNDER BAY ON P7B 5G7

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

Hogarth Riverview Manor
300 Lillie Street THUNDER BAY ON P7C 4Y7

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

Amended by SYLVIE BYRNES (627) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

An extension to compliance order #003 is granted to allow the home to achieve sustainable compliance. CDD date changed from August 19, 2019, to September 30, 2019.

Issued on this 14th day of August, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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Amended 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): April 23-26, 29, 30 and May 1-3, 6-9, 2019.

The following intakes were inspected upon during this Complaint inspection:

- Two intakes related to staffing concerns;

- Two intakes related to improper/incompetent treatment of residents; and

- One intake related to a fall and a significant change in status of a resident.

A Follow Up inspection #2019_633577_0012 and a Critical Incident System (CIS) inspection #2019_633577_0011 were conducted concurrently with this Complaint inspection.

During the course of the inspection, the inspector(s) spoke with the Regional Director for Extendicare, Administrator, two Directors of Care (DOCs), Clinical Managers, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Labour Relations Officer from the Ontario Nurses' Association (ONA), Staffing Coordinator, Staffing Clerk, Resident Assessment Instrument (RAI) Coordinators, Personal Support Workers (PSWs) and family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed staffing schedules and staffing patterns, reviewed relevant health care records, reviewed nursing union documentation, reviewed home's internal investigation notes, reviewed employee files, as well as reviewed licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Hospitalization and Change in Condition
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care
Sufficient Staffing

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

8 WN(s)
4 VPC(s)
3 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. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, that the licensee knew of, or that was reported to the licensee, was immediately investigated.

A complaint was submitted to the Director which alleged that, on an identified date, at specified time, resident #007 had care needs that were not completed. The complainant reported they were not sure if any of the residents attended an identified meal, or were provided with an identified meal and that residents were being neglected because of the staffing shortages in the home.

A Critical Incident System (CIS) report was submitted to the Director for the incident that occurred on an identified date. The report identified two alleged areas of neglect as: (1) resident #007 had been found with their care needs not completed at a specified time; (2) residents had not received an identified meal (resident #007 had not received the identified meal that date, eight other residents may not have received the same meal that date, and one resident had received a meal tray but had not been assisted to eat).

O. Reg. 79/10 defines neglect as the failure to provide a resident with the

treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A review of the home's policy, "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" revised April 2017, indicated that Extendicare had a zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated. The policy further indicated that all reported incidents of abuse and/or neglect would be objectively, thoroughly and promptly investigated.

Inspector #625 reviewed Clinical Manager #113's handwritten and typed notes from meetings with staff and family members conducted related to the incident on an identified date. The notes identified additional areas of alleged neglect including: (1) resident #016 had not received morning medications until a later time on an identified date; (2) resident #018 was required to be up for an identified meal at a specific time and was not out of bed until a later time, on an identified date; (3) on an identified date, resident #017's family member was overheard by an RPN state to the RN that they wished resident #017 would die as the resident was suffering and neglected; (4) on an identified date resident #007's family member had arrived at a specified time and observed that the resident had not received continence care since the previous night; and (5) resident #007 had to wait for up to 40 minutes for assistance at times, when their call bell was rung. The notes also identified the Clinical Manager had reviewed the Meal Consumption and Distribution Sheet to determine which residents had recorded intake.

Inspector #625 reviewed the Meal Consumption and Distribution sheet for a specific unit for an identified date, and noted that 32 out of 32 residents, or 100 per cent (100%) of residents on that specific unit, had blank and incomplete documentation for a specific hour fluid pass, and no staff person had recorded that the morning beverage pass had been completed including the actual time it was delivered, the name of the staff who delivered or the initials of the staff member who delivered the beverage pass.

A review of Dietary Reports for an identified date on a day shift, identified 22 out of 32, or 69 per cent, of residents had no documentation related to the offering or provision of two identified meals or a specified nourishment pass; and 32 out of 32 residents, or 100 per cent, of the resident had no documentation related to a

specified beverage pass.

During an interview with DOC #104, they acknowledged that allegations communicated to, or discovered by, the home's management when following up on the incidents that occurred on an identified date, were allegations of neglect that should have been investigated at the time they were identified. The DOC specifically identified the administration of morning medications being given at a later time to resident #016, and the Meal Consumption and Distribution sheet that was blank for all residents for the morning beverage pass, had not been investigated. [s. 23. (1) (a)]

2. A complaint was submitted to the Director which alleged that residents on a specific unit were found to have been incontinent overnight. The complainant further alleged that the incident had been reported to "administration"; they had been told that this incident had not required a report to the Ministry of Health and Long-Term Care.

During an interview with DOC #114, they confirmed that they and Clinical Manager #100 had received an email which described concerns from staff that residents on a specific unit had not received care during an identified round at a specified time on a specified date. The residents were found to be incontinent of urine on an identified shift, at a specified time. The DOC reported that RN #115, forwarded an email to them and Clinical Manager #100 regarding the care concerns.

Inspector #577 reviewed the email correspondence from RN #115, which outlined the following concerns from night staff:

- resident #020 was found 'soaking wet' from urinary incontinence upon completion of their round at a specified time; the previous shift had reported that they had changed resident #020 just prior to the time of the round;
- resident #023 was found to have been wearing their day incontinent product, and had not been placed in a night incontinent product;
- resident #024 was in bed and did not have their fall prevention strategies in place beside their bed;
- resident #021 did not have their specified intervention in place;
- resident #019 was placed into bed at an identified time and night staff found them positioned in the upright position; and
- resident #022 reported that the evening staff had offered to change their

incontinent product but had not returned to their room; the evening staff reported to the night staff that resident #022 had been aggressive and had refused care.

The email further indicated that this had been an ongoing concern where some Personal Support Workers (PSWs) were failing to complete their last evening round and as a result, night staff were finding residents incontinent of urine.

During an interview with Clinical Manager #116, they reported that they had received a phone call from RN #117 on an identified date, at a specified time, who had reported that residents on a specific unit were found with care issues during the night, as outlined in the email. Clinical Manager #117 reported that they notified the Administrator at that time.

During an interview with Clinical Manager #100, they reported to Inspector #577 that they had received an email on an identified date, from RN #115 which described care concerns from the staff on a specific shift, on an identified date. They further reported that their investigation entailed the viewing of video footage in two hallways, from the evening of an identified date, over a specified time period and concluded that staff had entered residents rooms and performed care. They confirmed with the Inspector that their investigation did not include any interviews with residents and staff.

During an interview with Extendicare Regional Director #109, they confirmed that the allegations should have been investigated and should have included staff and resident interviews. [s. 23. (1) (a)]

3. Two complaints were submitted to the Director on two identified dates. The complaint alleged staffing shortages of Registered Practical Nurses (RPNs), Registered Nurses (RNs), and the home's expectation that RNs fill the role for medication administration, which was not generally performed by them. Twenty three "Professional Responsibility Workload Reporting Forms" (PRWRFs) were received by the home over a specific four month period.The "PRWRF's" indicated that there were shifts where RNs had to complete medication administration for the residents due to staffing shortages with RPNs, and some RPNs were not working to their full scope. The completed forms indicated that on occasion, the RNs were unable to complete wound care treatments and other RN duties, which included assessments.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the

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.

Inspector #577 reviewed 23 "Professional Responsibility Workload Reporting Forms", and noted the following:

- on an identified date-there were multiple sick calls from RPNs on the day shift; three RNs were pulled to the medication cart on three different nursing units during the day shift; a resident had a change in their blood work where results were received at a specified time and the lab result had been passed onto an RN at an identified number of hours later, which had resulted in a delay in treatment;
- on that same date-eight complex wound care treatments were not completed on days or nights; and
- on another identified date-all scheduled wound care treatments were not done on days or nights.

Inspector #577 reviewed a letter dated on an identified date, in response to the "Professional Responsibility Workload Report", which had been addressed to the RNs from DOC #104. The letter acknowledged receipt of the "PRWRFs" dated on 12 identified dates; and that during those shifts they were short an RN as well as short RPNs for those shifts which required RNs to do the medication administration. The letter further acknowledged that working short had not provided the opportunity to have provided the care to the residents that should have been provided.

A review of the home's policy, "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-03", revised April 2017, indicated that all reported incidents of abuse and/or neglect would be objectively, thoroughly and promptly investigated.

During an interview with Clinical Manager #119, they reported to Inspector #577 that they had received the "PRWRF's" via email and they hadn't had any follow up with staff about care concerns documented on the forms.

During an interview with Clinical Manager #100, they reported that they had received the "PRWRF's" via email. They further reported that if care had not been completed, it was up to the nurse to communicate that to the next shift.

During an interview with Clinical Manager #116, they reported that the "PRWRF's" were received via email. They reported that when they had received the forms, they had not followed up or investigated whether the care was or was not completed.

During an interview with DOC #104, together with Inspector #577, the "PRWRF's" were reviewed specifically for two shifts on two identified dates. They reported that the forms were utilized as a workload issue and that there had been times when RNs were required to have completed medication administration. They further confirmed that they and the Managers had not followed up to determine whether care had not been provided. There were no investigation notes nor CIS reports completed. [s. 23. (1) (a)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was submitted to the Director alleging that multiple residents in the home had not received an identified meal on an identified date.

The corresponding Critical Incident System (CIS) report identified that there was no documentation that resident #015 received an identified meal.

During a review of resident #015's progress notes, Inspector #625 read a progress note entered by RPN #110 which identified that, on an identified date, the resident had been found in their room set up and strapped into a specific device, while in their chair unattended, for an approximate amount of time. The note indicated that PSW #120 had connected the apparatus to the specific device and then left the resident to find another staff member to assist with the transfer. A second progress note on an identified date, entered by RN #121 identified that the resident recalled the incident when assessed by the RN; the RN had

contacted the home's Administrator on call and had received direction from the Administrator, who had consulted with Extendicare Assist, to complete a Safety Report and a hard copy of a critical incident form to assist with the internal investigation. The progress notes did not identify that the Director had been notified of the incident.

The Inspector reviewed Ministry of Health and Long-Term Care records and was not able to locate notification via the After-Hours Line or the Critical Incident System that the home had notified the Director of the incident.

The Extendicare PowerPoint in use in the home titled "General Orientation Safe Lifting with Care Program" (undated) indicated that, when using a mechanical lift, staff were required to ensure a second staff member was present and ready to assist and two staff correctly placed the sling. The PowerPoint also identified that all staff were to be knowledgeable of their specific roles and responsibilities in the use of mechanical lifts.

The Extendicare policy in use in the home, "Mechanical Life Procedure - LP-01-01-03", revised August 2017, identified that, for a sit-to-stand lift, staff were to remain with a resident during the entire time the sling was connected to the mechanical lift.

The Extendicare policy in use in the home, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting – RC-02-01-02", revised April 2017, included a document titled, "Jurisdictional Reporting Requirements – Appendix 2", revised April 2017, which identified that in Ontario, the LTCHA provided that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director of the Ministry of Health and Long-Term Care.

A review of the home's investigation file included:

- an email on an identified date, from the Administrator to DOC #104 and Clinical Manager #100, which indicated that the Administrator had received a call the previous night regarding the incident and "It did not meet the criteria for a CIS" and needed to be investigated internally. The email thread included a forwarded email on an identified date, from RN #121 to the Administrator that identified resident #015 had been "left in error, strapped into the specific device in [their]

room by the PSW for an identified amount of time;
- an email from PSW #120 on an identified date, forwarded by the Administrator to Clinical Manager #100 and copied to DOC #104 on an identified date, indicated that the PSW had strapped resident #015 into the specific device while the resident remained seated in their chair. The email read "Because I am aware of the policies regarding lifts I intended to briefly step out of the resident's room to quickly grab a colleague to assist me in the transfer" and that the resident remained seated in their chair clipped into the specific device for an identified amount of time. The PSW wrote that they had asked two PSWs for assistance with the transfer but neither had been able to assist, and that the second PSW had been providing care to a resident and had asked PSW #120 to begin the care of another resident in the meantime, until they were able to come to their aid. Resident #015 remained clipped to the specific device for an identified amount of time as the PSW had "…completely forgot because I was assisting with the HS care of other residents while I waited for help, this was my mistake";
- a safety report which contained details consistent with those entered in the progress notes. The safety report contained the question "Was the patient or could the patient have been harmed?", and the corresponding response "True"; and
- a letter dated on an identified date, from DOC #104 to PSW #120 that identified the details of the incident which were consistent with the PSW's emailed account, and read "…in discussion you were not aware that part of the Safe Lifting with Care Program included that prior to applying a sling both staff that will be providing the lift needs to be present".

During an interview with RPN #110 they stated that resident #015 had been connected to a specific device by an apparatus, with no shoes on their feet, with their chair up close to the device, for an identified amount of time. The RPN stated that the resident had a specific medical impairment and required two staff to have been present for assistance with transfers for the specific device. The RPN stated that PSW #120 had left the resident connected when they went "a far distance" from the resident to find help with the transfer. The RPN stated that the home's training required two staff to be present to apply transfer apparatus' to residents, to ensure the apparatus' were correctly applied, to reduce the risk that the apparatus was improperly positioned and that the resident would fall out, but that PSW #120 had applied the apparatus alone. The RPN identified multiple ways the incident had put the resident at risk of harm. The RPN stated that they recalled that RN #121 had phoned the Administrator and asked them if the incident was reportable to the MOHLTC. The RPN stated that they did not know what the

Administrator told the RN but the RPN thought "for sure it was reportable" and that they thought that the Director would have been notified.

During an interview with RN #121 they confirmed that resident #015 had been left in an apparatus connected to a specific device for an identified amount of time. The RN indicated that leaving a resident in an apparatus, connected to a specific device, unattended for an identified amount of time was not providing proper care to the resident. The RN also indicated that the home's policy, which required staff to remain with residents the entire time the apparatus was connected to the specific device, had not been followed. The RN stated they had phoned the Administrator, who then consulted with Extendicare Assist [third party management in the home] and phoned the RN back with direction, which included completion of an internal safety report and a hard copy critical incident report. The RN stated that they had specifically asked the Administrator if they needed to complete an online critical incident report to notify the Ministry but that the Administrator told the RN that it was not within the RN's purview to do so. The RN stated that they were not directed to notify the Director/Ministry, no one told the RN to phone it in, and the RN stated "I just did what I was told".

During an interview with DOC #104, they acknowledged that resident #015 had been connected by an apparatus to a specific device for an identified amount of time without staff present. The DOC stated that the incident had been discussed during a management meeting that was held the Monday following the incident [the day after the incident occurred], where the home's Administrator, DOCs and Clinical Managers were present, but that the incident had not been reported to the Director. The DOC stated that the incident was a mistake, that the resident had not been harmed and that "ideal care" had not been provided. The DOC identified that the resident should not have been left unattended while connected to the specific device for an identified amount of time.

During an interview with Extendicare Regional Director #109, they stated that they were familiar with the incident as the Administrator had consulted with them when the incident happened. The Regional Director stated the Administrator described the incident as "low risk" and said there had been no risk of harm to the resident. The Regional Director stated they asked clear questions about the risk and harm to the resident and they would have needed to have full information and be fully apprised of what happened to determine if there had been a risk of harm. They stated the Administrator had formed the opinion that it was incompetent care, the PSW had not followed the policy for lifts and transfers, it was not intentional and

the PSW had not intended to leave the resident unattended. The Regional Director stated if there was a risk of harm to the resident, the incident would have been reported to the Director, but the Regional Director reiterated that the Administrator had informed them that the resident had not been at risk during the incident.

During an interview with the Administrator, they stated they were aware that the resident had been connected to a specific device while in a chair in their room, that a PSW put the resident in the apparatus attached to the specific device, went to look for help and didn't come back for quite some time. The Administrator acknowledged that the PSW had not followed the PowerPoint safe lift training presentation that identified two staff were required to apply the apparatus, as well as failed to follow the policy which identified the resident was not to be left unattended when connected to the specific device by the apparatus. The Administrator stated they told the RN that they would make a decision on whether or not to report it to the Director and would get back to the RN. They stated they then called the Extendicare Regional Director and talked it out and talked it through, following which they determined the incident didn't fit the description of incompetent care for reporting.

Further in the same interview the Administrator elaborated that the incident was not intentional and resulted from a mistake, and stated repeatedly that they did not believe that improper or incompetent care had been provided, but that two staff should have been present and the policy had not been followed. The Administrator stated they contacted the RN back, who was "fairly new" and told them that they didn't need to call the After-Hours number to report the incident, but that they were to complete a paper critical incident report. The Administrator stated that there was a risk of harm occurring to the resident as the resident "wasn't able to get out", but repeatedly identified that the incident had not been reported to the Director, as improper or incompetent care had not occurred. [s. 24. (1) 1.]

2. A complaint was submitted to the Director regarding resident #002 who had experienced an incident and the care provided after the incident. The complainant alleged the resident had an injury on an identified area of their body, had been administered a specific medication within a half an hour after the injury, and the residents health subsequently declined; the incident had not been reported to the Ministry of Health and Long-Term Care (MOHLTC).

An additional complaint was submitted to the Director regarding this same incident involving resident #002. The complainant had concerns regarding the care provided after the incident, the administration of a specific medication after the incident, and the decline in the resident's condition afterward.

The licensee's policy, "Mandatory and Critical Incident Reporting (ON) RC-09-01-06", revised April 2017, indicated the following:

- the home would report and submit all Mandatory and Critical Incidents to the Ministry of Health and Long Term Care, within the required timeframes, in accordance to the Ontario Long Term Care Homes Act, 2007;
- the Director of Care /Designate were required to inform the MOH Director immediately, in as much detail as was possible in the circumstances of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; and
- make a report immediately following an incident, and if it was after normal business hours, report using the Ministry's method for after-hours emergency contact.

Inspector #196 reviewed the health care records for resident #002. A progress note on an identified date, indicated resident #002 had an incident in a specific area of the home which had been witnessed by non-staff members. The witnesses stated that the resident was trying to give way to someone and the resident traveled on an uneven area, and experienced an incident. The notes indicated the Substitute Decision Maker (SDM) and the Physician was notified. In addition, the notes contained the details of an assessment that was conducted, and the initiation of a specific routine.

A progress note on an identified date, with a particular focus, indicated a particular assessment of the resident was conducted at an identified approximate time. Findings included a specific injury to the resident, and a particular assessment with a specific numeric scale. The note also identified that Physician #122 was notified at an identified time regarding resident #002's current condition; that the MD had been made aware of the incident the previous evening; however, the incident had been described to them as the resident had slid from their mobility aid; and it had been mistakenly reported to them last evening that the resident was not on a specific medication. In addition, the progress note provided clarification that the resident was taking a specific medication and that Physician #122 could not differentiate at that time whether the resident's symptoms were

from their specific medical condition or possible specific injury from the incident. The electronic medication administration record (eMAR) identified that a specific medication had been administered twice daily at specific times the weeks previous to the fall. In addition, a dose was recorded as administered at an identified time on an identified date, approximately one half hour after the incident. A particular assessment , as in MED e-care, was completed on an identified date, and did not identify that the resident was currently on a specific medication; although, there was an option to have selected the specific medication on the assessment.

The investigation file for the resident's incident on an identified date, was reviewed. The homes' internal incident report identified that the incident had occurred at an approximate time on an identified date. The hand written notes from the video review of the resident's incident indicated that it had appeared that the resident may have hit an identified area of their body.

During an interview with RPN #123, they confirmed they had worked the night of resident #002's incident. They reported the resident was trying to get out of the way of another resident and experienced an incident where they had injured an identified area on their body. They further reported that the RN had administered a specific treatment on an identified area on their body. When asked by the Inspector whether the resident was taking a particular medication or if they had administered the particular medication to the resident after the fall they reported that after a fall, they usually held a particular medication, but couldn't recall that it wasn't given that shift.

During an interview with RN #124, they reported that they were working on the shift when resident #002 had experienced an incident and stated bystanders said that the resident may have hit an identified area of their body. RN #124 had spoken to Physician #122 and reported the resident had an incident and had told the physician that they may have hit an identified area of their body and could not recall telling the physician that they were or were not on a particular medication. They further reported to the Inspector they didn't know the resident was taking a particular medication.

During an interview with RN #125, they reported to the Inspector that they had spoken to Physician #122 and the physician had said they did not know that the resident was on a particular medication, and that the resident's incident had been described as a slide out of the mobility aid. The RN further reported that they had

a discussion with Clinical Manager #100 regarding the particular medication that had been given after the incident, the significant change in the resident's condition and whether this should be reported to the MOHLTC. The RN then reported that the Administrator had stated that they had spoken to the MOHLTC and said the incident was not reportable.

During an interview with Clinical Manager #100, they confirmed that they had reviewed the video of resident #002's incident the following day and had made hand written notes of the review that were within the investigation file and notes from a discussion with Physician #122. They reported to the Inspector, that Physician #122 had not been informed that the resident took a particular medication when the incident had first been reported to them, and had not been informed that the particular medication had been administered to the resident approximately one half hour after the incident. They further reported, after talking with Physician #122 the day after the incident, the physician would have sent the resident to the hospital had they known the resident had hit an identified area of their body.

During a further interview with Clinical Manager #100, they reported that they had received direction from the Administrator to not report this incident to the Director at the MOHLTC.

Together with the Inspector, DOC #104, reviewed the progress note documented on an identified date, at a specified time, by RN #125. During discussion of the progress note, which included the mechanism of the resident's incident; the Physician being unaware that the resident was on a particular medication; and that the particular medication being given approximately a half hour after the incident, DOC #104 acknowledged that this could have been reported as incompetent care based upon this information.

During an interview with Extendicare Regional Director #109, they reported that their process included the Administrator to have contacted the Extendicare Regional Director to inform of areas of resident risk, or potential risk. They added that Hogarth Riverview Manor was a home in their portfolio; and they had not been informed of this incident until the week of the inspection, during the time that the Inspector was speaking to the DOC. They further confirmed that they would have provided direction to report to the Director MOHLTC, for improper care, based upon the information known. [s. 24. (1) 1.]

3. The licensee has 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 occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, s.5, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the Director which alleged that residents on a specific unit were found to have been incontinent overnight. The complainant further alleged that the incident had been reported to administration, and had been told that this incident did not require a report to the Ministry of Health and Long-Term Care.

Refer to WN #1-finding #2 for further details.

During an interview with DOC #114, they confirmed that they and Clinical Manager #100 had received an email which described concerns from staff that residents on a specific unit had not received care rounds during a specified round on an identified date. The residents were found to be incontinent of urine on a specified shift. They further reported that RN #115 had forwarded an email to them and Clinical Manager #100 regarding the care concerns.

A review of the home's policy, "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" revised April 2017, indicated that Extendicare had a zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated. The policy further indicated that anyone who suspected or witnessed neglect that caused or may cause harm to a resident was required to contact the Ministry of Health and Long Term Care.

A review of the homes policy, "Extendicare-Mandatory and Critical Incident Reporting – RC-09-01-06", revised April 2017, indicated that the home was to inform the MOH Director immediately, in as much detail as was possible, improper or incompetent treatment or care of a resident that resulted in harm or a

risk of harm to the resident; mandatory reporting under the LTCHA, section 24(1) of the LTCHA required a person to make an immediate report to the Director where there was a reasonable suspicion that certain incidents occurred or may occur: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

During an interview with Clinical Manager #100, they reported that they had received an email on an identified date, from RN #115 which described care concerns brought forward by the staff working a specified shift on an identified date. They reported that the On-call Manager #116 had received a phone call from RN #117 on the morning of an identified date, who reported that residents on a nursing unit were found with care issues. They further reported that these concerns were not reported to the Ministry of Health and Long-Term Care as the Administrator stated it was performance issues with staff, it would be an internal investigation and would not be reported to the Ministry.

During an interview with Clinical Manager #116, they reported to Inspector #577 that they were the On-call Manager on an identified date, and had received a phone call from RN #117 at a specified time, who had reported that residents on a specific unit were found with care issues during a specified shift, as outlined in the email. Clinical Manager #116 reported that they notified the Administrator, who directed them that these were performance issues with staff and directed them not to report it to the Ministry as no one was harmed.

During an interview with DOC #114, they reported they were aware of the reporting requirements and had been directed by the Administrator to not report this incident to the Ministry.

During an interview with Extendicare Regional Director #109, they confirmed with Inspector #577 that the resident care concerns that were documented in the email should have been reported to the Director. [s. 24. (1) 2.]

4. Two complaints were submitted to the Director on two identified dates, which alleged staffing shortages of RPNs and RNs.

Refer to WN #1-finding #3, for details.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the 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.

Inspector #577 reviewed 23 "Professional Responsibility Workload Reporting Forms", and noted the following:

- on an identified date-there were multiple sick calls from RPNs on the day shift; a resident had a change in their blood work where results were received at an identified time and passed onto an RN at a specific number of hours later, which had resulted in a delay in treatment;

- on that same date-eight complex wound care treatments were not completed on days or nights; and

- on another identified date-all scheduled wound care treatments were not done on days or nights.

Inspector #577 reviewed a letter regarding "Professional Responsibility Workload Report Forms" dated on an identified date, addressed to the RNs from DOC #104. The letter acknowledged receipt of the "PRWRFs" dated on 12 identified dates; and that during those shifts they were short an RN(s) as well as short RPNs for those shifts which required RNs to do the medication administration. The letter further acknowledged that working short had not provided the opportunity to have provided the care to the residents that should have been provided.

During an interview with RN #125, they reported that they had submitted "PRWRFs" because wound care treatments weren't being completed as ordered, there were delays in completing assessments, and RNs were required to have completed medication administration when the home was short staffed for RPNs.

During an interview with RN #126, they reported that they had submitted "PRWRFs", as frequently the RNs were required to have completed medication administration when the home was short RPNs, and there were times when wound care treatments and/or assessments would not be completed.

During an interview with RN #127, they reported that when the home had been short in their complement of RPNs, the RNs were responsible for medication administration, and daily wound care treatments were not being completed.

During an interview with RN #128, they reported the main concern for submitting "PRWRFs" was related to the home's requirement that RNs complete medication administration when the home had been short RPNs and wound care treatments had not been completed as ordered and would have been missed for a few days.

During an interview with Clinical Manager #119, they reported to Inspector #577 that they had received the "PRWRFs" via email and they hadn't had any follow up with staff related to the care concerns documented on the forms as it's a union tool related to workload.

During an interview with Clinical Manager #100, they reported that they had received the "PRWRFs" via email. They reported that if care was not completed, it was up to the nurse to communicate it to the next shift.

During an interview with Clinical Manager #116, they reported that the "PRWRFs" were received via email. They reported that when they had received the forms, they had not followed up or investigated whether the care was or was not completed.

During an interview with DOC #104, together with Inspector #577, reviewed the "PRWRFs", specifically for two shifts on two identified dates. They reported that the forms were utilized as a workload issue and that there had been times when RNs were required to have completed medication administration. They further confirmed that they and the Managers had not followed up to determine whether care had not been provided, nor was it reported to the Director. [s. 24. (1) 2.]

5. A complaint was submitted to the Director which alleged that, on an identified date, at a specified time, resident #007 had care needs that were not completed. The complainant reported they were not sure if any of the residents were provided with an identified meal on an identified date. The complainant identified that the specific unit had been operating with less staff than the usual scheduled staff complement due to sick calls and stated that residents were being neglected because of the staffing shortages in the home.

Refer to WN #1-finding #1, for details.

Inspector #625 reviewed an after hours phone call report submitted by the home on an identified date, for an incident that occurred five days prior, on an identified

date. The log identified that improper care had occurred as residents #007, #009, #010, #011, #012, #013, #014 and #015, all missed an identified meal as reported by family.

A CIS report was submitted to the Director on an identified date, for the incident that occurred on an identified date. The report identified that:

- on an identified date, resident #007's family member had informed Clinical Manager #113 that a specific unit had been short one PSW during a specified time frame and resident #007 had care needs that were not completed at an identified time;
- on the following day, three family members met with DOC #104 and Clinical Manager #113 and resident #017's family member reported eight residents had not received a specific meal on an identified date;
- on the day after that, RPN #129 informed Clinical Manager #113 that resident #011 had received a tray but had not been assisted to eat a specific meal; and
- two days later, a review of the investigation conducted with the home's management team determined that, based on the family member's account [documented in the report as provided] several of the residents may have missed the identified meal, and the incident was called in to the MOHLTC after hours number.

Inspector #625 reviewed Clinical Manager #113's notebook and identified entries related to the incident on an identified date, as follows:

- on an identified date, during a meeting with Clinical Manager #113, resident #007's family member detailed allegations of care needs that were not completed . The notes also identified the resident would have to wait for up to 40 minutes for assistance when their call bell was rung;
- on that same identified date, the Clinical Manager spoke with PSW #130 who stated resident #017's family member reported that eight residents had not received an identified meal, but that the PSW believed possibly four residents had not received an identified meal;
- the following day, Clinical Manager #113 and DOC #104 met with resident #007, #016 and #017's family members who shared various concerns about the incidents on an identified date, including that resident #016 received morning medications at a later time, that eight specific residents had not had an identified meal, that resident #018 required another specified meal at a specified time and was not out of bed until a later time; and

- on an identified date, Clinical Manager #113 met with RPN #129 who stated that, on an identified date, resident #011 did not get to eat due to "timing/staffing" and that they overheard resident #017's family member state to the RN that they wished the resident would die as the resident was "suffering here/neglect".

A review of typed notes in the home's investigation file included details consistent with those in the notebook. The typed notes elaborated on a comment made on an identified date, shared with Clinical Manager #113 by RPN #129 on an identified date, that resident #017's family member said to RN #126 they wished the resident "would die because [they are] suffering here and being neglected".

During an interview with DOC #104, they acknowledged that allegations communicated to the home's management about the incidents that occurred on an identified date, were allegations of neglect that should have been reported to the Director at the time that they were identified. [s. 24. (1) 2.]

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 O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:
1. A falls prevention and management program to reduce the incidence of falls and the risk of injury. O. Reg. 79/10, s. 48 (1).
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions. O. Reg. 79/10, s. 48 (1).
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable. O. Reg. 79/10, s. 48 (1).
4. A pain management program to identify pain in residents and manage pain. O. Reg. 79/10, s. 48 (1).

Findings/Faits saillants :

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

Two complaints were received by the Director on two identified dates, which alleged staffing shortages of RPNs and RNs. Twenty three "Professional Responsibility Workload Reporting Forms" (PRWRF) were received by the home over an identified four month period. The completed forms indicated that on occasion, the RNs were unable to complete wound care treatments and other RN duties, which included assessments.

Inspector #577 reviewed 23 "Professional Responsibility Workload Reporting Forms", and noted the following:

- on an identified date-there were multiple sick calls from RPNs on the day shift; three RNs were pulled to the medication cart on three different nursing units during the day shift;
- on that same date-eight complex wound care treatments were not completed on days or nights; and
- on an identified date-all scheduled wound care treatments were not done on

days or nights.

Inspector #577 reviewed the 'RN Report' sheets for two identified dates, which indicated that four residents required daily treatments to have been completed by an RN.

A review of the home's "Skin and Wound Program: Wound Care Management - RC-23-01-02", revised February 2017, indicated that staff were to document all skin breakdown in the progress notes and surveillance tools, complete the "Bates-Jensen Assessment" every 7 days for pressure ulcers/venous stasis or ulcers of any type; complete the "Impaired Skin Integrity Assessment" for all other skin impairments, and record the treatment regimen on the Electronic Medication Administration Record (eMAR) and/or Electronic Treatment Administration Record (eTAR).

During an interview with Clinical Manager #116, they reported to Inspector #577 that staff were required to document their treatments on the eMAR and a particular assessment record for altered skin integrity with each treatment.

During an interview with Clinical Manager #100, they reported that staff were required to document treatments on the eMAR, and on a particular assessment record for altered skin integrity with every treatment. They further reported that if there wasn't any documentation in those two areas, then the treatments hadn't been done. They further reported that that the another particular assessment record was the clinical tool utilized for weekly assessments for a specific type of altered skin integrity.

During an interview with RPN #131, they reported that registered staff were required to have documented on the eMAR and on a particular assessment record for altered skin integrity with every treatment. They further reported that weekly documentation was required on two other particular assessment records for two specific types of altered skin integrity.

During an interview with RPN #132, they reported that staff were required to have documented on a particular assessment record and the eMAR with every treatment.

a) Inspector #577 reviewed resident #004's treatment orders on an identified date,

following a medical intervention. The resident had required daily treatments for two areas of altered skin integrity.

In a review of resident #004's particular assessment record for altered skin integrity, over an identified three month period, Inspector #577 identified daily treatments were not documented on the following days:
-five days for an identified month, for one area of altered skin integrity;
-seven days for an identified month, for another area of altered skin integrity;

-12 days for an identified month, for one area of altered skin integrity;
-11 days for an identified month, for another area of altered skin integrity;

-13 days for an identified month, for one area of altered skin integrity;
-15 days for an identified month, for another area of altered skin integrity;

In a review of resident #004's eMAR over an identified three month period, the Inspector identified daily treatments were not documented on the following days:
-13 days for an identified month, for an area of altered skin integrity;
-18 days for an identified month, for another area of altered skin integrity;

-14 days for an identified month, for an area of altered skin integrity;
-22 days for an identified month, for another area of altered skin integrity;

-12 days for an identified month, for an area of altered skin integrity;
-22 days for an identified month, for another area of altered skin integrity.

A review of another particular weekly assessment for resident #004, revealed a gap of 21 days, for an identified month, where there were no weekly assessments completed; missing weekly documentation for a week in another identified month; and a gap of 15 days and the last week in the next identified month where there were no weekly assessments completed.

b) Inspector #577 reviewed resident #008's treatment orders for an area of altered skin integrity, where they required daily treatment. An additional order for another area of altered skin integrity required treatment three times per week.

In a review of resident #008's particular assessment record for altered skin integrity, over an identified three month period, Inspector #577 identified daily

treatments were not documented on the following days:
-11 days for an identified month, for one area of altered skin integrity;
-11 days for an identified month, for another area of altered skin integrity.

In a review of resident #008's eMAR, over an identified three month period, Inspector #577 identified daily treatments were not documented on the following days:
-10 days for an identified month, for one area of altered skin integrity;
-documented once for the first and third week of an identified month, for another area of altered skin integrity;

-11 days for an identified month, for one area of altered skin integrity;
-documented once for the first week, and twice for the second and fourth weeks of an identified month, for another area of altered skin integrity;

In a review of the eMAR for an identified month, Inspector #577 identified treatment orders for an area of altered skin integrity had changed to three times per week; and were documented twice for the first week, no documentation for the second week, and once for the third and fourth week of an identified month;
-documented once for the third and fourth week, and no documentation for the second week of an identified month, for another area of altered skin integrity.

A review of another particular weekly assessment for resident #008, revealed a gap of 36 days between two identified months, where there were no weekly assessments completed; a gap of 18 days for another identified month, where there were no weekly assessments completed.

c) Inspector #577 reviewed resident #006's treatment orders for an area of altered skin integrity, where they required a particular treatment three times a week and another treatment daily.

In a review of resident #006's particular assessment record for altered skin integrity, over an identified three month period, Inspector #577 could not determine when the treatment was completed. The documentation was inconsistent and the Inspector found 42 of 53 days or 80 per cent of the time, the assessment record had not indicated that treatment was completed, as was required.

In a review of resident #006's Emar for an identified month, Inspector #577

identified that treatments had been documented once for the first week.

In a review of resident #006's Emar for an identified month, Inspector #577 identified that treatments had been documented once for the third week, and no documentation for the second and fourth week.

In a review of resident #006's Emar for an identified month, Inspector #577 identified that treatments had been documented once for the first and fourth week, and no documentation for the second and third week.

During an interview with DOC #104, they reported to Inspector #577 that staff were required to have documented on the eMAR and a particular assessment record with every treatment; another particular assessment record was required once a week for wound ulcers and another particular assessment record for skin tears. DOC #104 and the Inspector reviewed the incomplete documentation for residents #004 and #008, over an identified four month period. The DOC confirmed that staff had been inconsistent with their skin assessment documentation. They further confirmed that the treatments were not completed if it wasn't documented both on the eMAR and a particular assessment record and staff had not implemented or followed the Wound Program.

During an interview with DOC #114, they reported to Inspector #577 that staff were required to have documented on the eMAR and a particular assessment record with every treatment. DOC #114 and the Inspector reviewed the incomplete documentation for resident #006 over an identified three month period. They confirmed that staff had been inconsistent with their assessments and documentation, and it had been unclear when staff had completed the particular assessment. [s. 48. (1) 2.]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 003

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other.

A complaint was received by the Director regarding resident #002 who had experienced an incident and the care provided after the incident.

Please refer to Refer to WN #2 , finding #2 for further details.

Inspector #196 reviewed the health care records for resident #002. A progress note on an identified date, indicated resident #002 had an incident in a specific area of the home. The notes further indicated the physician was notified and included the details of an assessment that was conducted, and the initiation of a particular assessment.

A progress note recorded the following day, identified that Physician #122 had been made aware of the incident the previous evening; however, the incident had

been described to them as the resident had slid from their mobility aid; and it had been mistakenly reported to them last evening, that the resident was not on a particular medication. A particular tool, as in Mede Care, was completed on an identified date, and did not identify that the resident was currently on a specific medication.

The investigation file for resident's incident on an identified date was reviewed. The home's internal incident report identified that the incident had occurred at an approximate time on an identified date. The hand written notes from the review of the video of the resident's incident indicated that it appeared that the resident may have hit an identified area of their body.

During an interview with RPN #123, they reported that the resident experienced an incident where they had injured an identified area on their body.They further reported that the RN had administered a specific treatment on an identified area on their body. When asked by the Inspector, whether the resident was taking a particular medication or whether they had administered the particular medication to the resident after the incident, they reported that after an incident, they usually held a particular medication, but couldn't recall whether it wasn't given that shift.

During an interview with RN #124, they reported that they were working on the shift when resident #002 had an incident and stated bystanders said that the resident may have hit an identified area of their body. They had spoken to the Physician #122 and reported the resident had an incident and that they may have hit an identified area of their body and that they could not recall telling the physician that they were or were not on a particular medication. They further reported to the Inspector they didn't know the resident was taking a particular medication.

During an interview with RN #125, they reported that there was a bump on an identified area of their body when assessed the morning after the incident. They added that RN #124 told them that a treatment had been applied to an identified area of their body during the night shift. Together with the Inspector, after a review of the night shift progress notes on an identified date, they confirmed there was no notation of a treatment being applied to the resident or a raised area identified on an area of their body.

During an interview with Clinical Manager #100 they confirmed that they had viewed the video of resident #002's incident the following day and had made the

hand written notes of the review that were within the investigation file and notes from a discussion with Physician #122 . They reported to the Inspector, that the physician had not been informed that the resident took a particular medication when the incident had first been reported to them, and had not been informed that the particular medication had been administered to the resident approximately one half hour after the incident. They further reported, after talking with the physician, the day after the incident, the physician reported that they would have sent the resident to the hospital had they known the resident had hit an identified area of their body.

During an interview with Physician #122, they reported to the Inspector that they had been notified of resident #002's incident on the evening it had occurred. The Physician indicated that the details of the incident were unclear as they didn't know specific details that had occurred. At the time, the Physician had asked the staff whether the resident was on a particular medication and they answered "no". They further reported it was a calamity of errors, not well communicated and better questions should have been asked about the incident and the particular medication. They added they were made aware the following morning, during a phone call with the RN, that the resident was on a particular medication and it had been administered after the incident, and at that time, it was put on hold. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other in the assessment of the resident so that their assessments were integrated and were consistent with and complemented each other, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

A complaint was submitted to the Director which alleged that, on an identified date, resident #007 had care needs that were not completed. The complainant reported they were not sure if any of the residents attended a specific meal, or were provided with a specific meal on the morning of an identified date. The complainant identified that the unit had been operating with less staff than the usual scheduled staff complement due to sick calls and stated that residents were being neglected because of the staffing shortages in the home.

A review of the licensee's policy, "Zero Tolerance of Resident Abuse and Neglect Program – LTC 5-50", revised March 21, 2018, identified that the home had adopted the attached Extendicare policy effective November 28, 2018, and the HRM Specific Abuse and Neglect Decision Tree effective December 23, 2017.

a) The attached Extendicare documents included a policy, "Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01", revised April 2017, identified that the home would implement measures to promote fulsome and timey internal and external reporting and disclosure of resident abuse and neglect. The policy titled "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting – RC-02-01-02", last updated April 2017, identified that disclosure of the alleged abuse would be made to the resident/SDM/POA, immediately upon becoming aware of the incident.

A CIS report was submitted to the Director for the incident that occurred on an identified date. The report identified that attorneys for personal care for residents #009, #010, #011, #012, #013, #014 and #015, were not notified of the allegations of neglect that occurred on an identified date, until eight days later.

During an interview with RPN #136, they stated that on an identified date, night shift, they had been sent an email from Clinical Manager #113 which asked the RPN to contact eight residents' families about the allegation that the residents may not have had a specific meal on an identified date. The RPN stated they replied to the email that they were not comfortable telling the families as the RPN had relationships with them and did not feel that telling them on an identified evening that something that happened the previous weekend was their role.

During an interview with RN #128, they stated that they had contacted seven or eight families on an identified date, at the direction of Clinical Manager #113 to inform them of the alleged neglect that occurred on an identified date. The RN stated that the families should have been notified in a timely manner and that the home's zero tolerance of abuse policy was not followed with respect to notification of families.

During an interview with DOC #104, they stated that the resident's families should have been notified, as per the home's zero tolerance of abuse policy.

b) The attached Extendicare documents included a policy titled, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting – RC-02-01-02", revised April 2017, identified that any employee or person who became aware of an alleged, suspected or witnessed resident incident of abuse or neglect was to report it immediately to the Administrator/designate/reporting manager or if unavailable, to the most senior Supervisor on shift at that time.

A review of handwritten and typed notes in the home's investigation file identified that, on an identified date, RPN #129 informed Clinical Manager #113 that resident #011 did not eat a specific meal on an identified date, due to "timing/staffing" and that they overheard resident #017's family member state to RN #126 that they wished the resident "would die because [they are] suffering here and being neglected". The investigation file did not identify that the failure to provide resident #011 with a specific meal or the allegation that resident #017's family member made to RN #126 overheard by RPN #129 that the resident had been suffering and neglected, were reported internally as identified in the policy.

During an interview with PSW #130, they stated that they had worked on an identified date, and knew that some residents had missed a specific meal, they didn't know who specifically had missed the meal at the time, but found out who they were later. The PSW also stated that the specific beverage pass did not get completed as the unit was working with only two PSWs, and, when working with two PSWs "things can't get done" because, even when the unit worked fully staff with three PSWs they rushed to get everything done.

During an interview with DOC #104 they stated that RN #126 had called them regarding another item on an identified date, and stated to the DOC that, while they had the DOC on the phone, there were two family members on the unit that were upset with a meal service, that the RN had confirmed that everyone ate, all care was provided, nothing was missed and that the RN spoke with the families and they were okay. The DOC stated they had not been informed that resident #017's family member specifically alleged "neglect" had occurred when speaking to RN #126 and as overheard by RPN #129. The DOC stated the RN and RPN had roles and responsibilities to follow when hearing a family member alleged neglect in the context of what had occurred that shift and should have followed the zero tolerance of abuse and neglect policy. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with., to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting residents.

A complaint was submitted to the Director which alleged that multiple residents in the home had not received a specific meal on an identified date.

During a review of resident #015's progress notes, Inspector #625 read a progress note entered by RPN #110 which identified that, on an identified date, the resident had been found in their room set up and strapped into a specific device, while in their chair unattended, for an approximate amount of time. The note indicated that PSW #120 had connected the apparatus to the specific device and then left the resident to find another staff member to assist with the transfer.

A review of the home's investigation file included an email dated on an identified date, from PSW #120, forwarded by the Administrator on an identified date, to Clinical Manager #100. The PSW's email identified they had strapped resident #015 into the specific device while the resident remained seated in their chair. The email read "Because I am aware of the policies regarding lifts, I intended to briefly step out of the resident's room to quickly grab a colleague to assist me in the transfer" and that the resident remained seated in their chair clipped into the specific device for an approximate amount of time. The PSW wrote that they had "completely forgot….this was my mistake".

A review of an Extendicare training PowerPoint in use in the home titled "General Orientation Safe Lifting with Care Program" (undated) identified that staff were to assess the situation and create a safe work environment by ensuring a second staff member was present and ready to assist with a mechanical lift transfer. The PowerPoint indicated, when transferring a resident, two staff were required.

A review of the Extendicare policy in use in the home, "Mechanical Life Procedure

- LP-01-01-03", revised August 2017, identified that, when using a sit-to-stand lift, staff were to remain with the resident during the entire time the sling was connected to the mechanical lift.

During an interview with RPN #110, they stated that resident #015 had been connected to a specific device via an apparatus from the time PSW #120 left the resident to seek assistance with the transfer until the RPN found the resident. The RPN stated that, they observed the resident hooked up to the specific device and "ready to go", with their feet on the pedals of the device, wearing no shoes, with the lift straps applied and the chair up close to the lift. The RPN identified that there was a risk of harm to the resident as the resident was left unattended in that manner. The RPN also identified that, during lift and transfer training provided by the home, the staff were instructed that application of apparatus' required two staff present, and the apparatus had been applied by only one staff person.

During an interview with RN #121 they confirmed that resident #015 had been left in a apparatus connected to a specific device for an identified amount of time. The RN acknowledged that leaving a resident in an apparatus, connected to a specific device, unattended for one hour was not providing proper care to the resident. The RN acknowledged that the home's policy had not been followed as staff were to remain with residents the entire time the apparatus was connected to the specific device.

During an interview with PSW #133, a "super user" who provided hands-on training on safe lifts and transfers to staff and students in the home, they stated that two staff needed to be present for the entire transfer using a specific device, from start to finish, including for the application of the apparatus. The PSW identified that a resident should not be left alone when connected to a specific device in an apparatus. The PSW also identified that it was not safe to connect apparatus straps unless two staff were present as someone may put the apparatus on improperly and two staff needed to be present for all of it, to make sure the apparatus was on right.

During an interview with Clinical Educator #134, they stated that two staff were required to apply an apparatus when using a specific device and that there was a risk of harm for a resident to be left in an apparatus connected to a specific device unattended. The Clinical Educator acknowledged Extendicare's training PowerPoint on safe lifting and the home's policy on safe lifting which identified that two staff were to be present to correctly position the apparatus, and that staff

were to remain with the resident during the entire time the apparatus was connected to the lift when using the specific device, respectively.

During an interview with DOC #104, they acknowledged that resident #015 had been connected by the apparatus to a specific device for an identified amount of time without staff present. The DOC stated that the care was "not ideal care" and that the resident should not have been left connected to the specific device for an identified amount of time unattended.

During an interview with Extendicare LTC Consultant #135, they reviewed the progress note for an identified date and stated the home's policy had not been followed as the care provided had not been in accordance with the policy. They acknowledged that the progress note identified that the PSW had left the resident to get help with the transfer, and acknowledged that the resident had not been provided with the assistance required for safety as outlined in the policy.

During an interview with Extendicare Regional Director #109 they stated that the PSW had not followed the Extendicare lift policy and the resident should have been with staff at all times when connected to the specific device by an apparatus.

The Administrator acknowledged that the PSW had not used safe lifting and transferring techniques when transferring the resident as they did not follow the policy. [s. 36.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff use safe transferring and positioning devices or techniques when assisting residents, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (a) three meals daily; O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of three meals daily.

A complaint was submitted to the Director which alleged that on an identified date, at a specified time, resident #007 had not been fed a specific meal, and the complainant was not sure if any of the residents on the unit had attended a specific meal, or were provided with a meal that morning.

Inspector #625 reviewed an after hours phone call report submitted to the Director by the home for the incident on an identified date, which identified that improper care had occurred as residents #007, #009, #010, #011, #012, #013, #014 and #015, all missed a specific meal as reported by a family.

A (CIS) report was submitted to the Director for the incident that occurred on an identified date, and identified that residents #007, #010 and #012 were not woken and offered a specific meal, resident #011 was provided with a tray but their intake was not accounted for and nursing staff could not confirm intake provided, and resident #015 had no documentation related to a specific meal and staff could not confirm if they were offered the meal.

The Inspector reviewed Dietary Reports for the residents on a specific unit for an identified date, and identified that 22 out of 32, or 69 per cent, of the residents on the unit had no documentation of the provision or offering of an identified meal.

During an interview with RPN #136 they stated that residents #007, #010 and #012 should have been offered a specific meal, and resident #011 should have been provided with assistance to eat a specific meal on an identified date.

During an interview with DOC #104, they acknowledged that, on an identified date, as per the CIS report, the home's investigation determined that residents #007, #010 and #012 had not been offered or provided with a specific meal; resident #011 had not been provided with the assistance they required to consume a specific meal; and the home was not able to determine whether resident #015 had received a specific meal or not. The DOC acknowledged that residents should have been offered and provided with a specific meal. [s. 71. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident was offered a minimum of three meals daily, to be implemented voluntarily.

WN #8: 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 has failed to ensure that when a resident has fallen, the resident was assessed and where the condition or, circumstances of the resident require, a post-fall assessment was conducted.

A complaint was received by the Director regarding resident #002 who had experienced an incident and the care provided after the incident.

Please refer to Refer to WN #2 , finding #2 for further details.

A review of the licensee's policy, "Falls Prevention and Management Program" RC-15-01-01", revised February 2017, indicated that if a resident hits their head or was suspected of hitting their head (e.g., unwitnessed fall), staff were to complete the Clinical Monitoring Record, Appendix 10, as follows:
- monitor Neurovital Signs every hour for four hrs, then every eight hrs for 72 hrs (if head/brain injury suspected or the fall was unwitnessed); and
- monitor vital signs; assess for pain; and monitor for changes in behaviour.

Inspector #196 reviewed resident #002's health care records and found that specific monitoring was not completed at a particular hour, and the word "sleeping" was handwritten on the monitoring record.

During an interview with RPN #123, they reported to the Inspector that they were aware that resident #002 had experienced a specific incident where they had injured an identified area on their body, as per the report that had been given to them by the RNs. They confirmed that the particular routine as marked on the monitoring record, was to be done every hour for the first four hours, and included specific monitoring every hour, then done every eight hours after that time, for 72 hours. They reported that the resident was sleeping at a particular hour and they did not wake them to complete a specific routine.

During an interview with DOC #104, they reported that staff were expected to follow the Falls policy, specific to a particular routine, after a resident had an specific incident. Together with the Inspector, the monitoring record for resident #002 was reviewed and they confirmed that the particular routine should have been completed, and staff should not have documented "sleeping" on the monitoring record. [s. 49. (2)]

Issued on this 14th day of August, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SYLVIE BYRNES (627) - (A1)
Inspection No. / No de l'inspection :	2019_633577_0010 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	001759-19, 004010-19, 004242-19, 007000-19, 009356-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Aug 14, 2019(A1)
Licensee / Titulaire de permis :	St. Joseph's Care Group 35 North Algoma Street, THUNDER BAY, ON, P7B-5G7
LTC Home / Foyer de SLD :	Hogarth Riverview Manor 300 Lillie Street, THUNDER BAY, ON, P7C-4Y7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Sheila Clark

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

To St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 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. 23. (1) Every licensee of a long-term care home shall ensure that,

(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:

(i) abuse of a resident by anyone,

(ii) neglect of a resident by the licensee or staff, or

(iii) anything else provided for in the regulations;

(b) appropriate action is taken in response to every such incident; and

(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee must be in compliance with s. 23 (1) of O. Reg. 79/10. Specifically the licensee must:

1) Ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone, neglect of a resident by the licensee or staff that the licensee knows of, or that is reported to the licensee, is immediately investigated.

2) Ensure that appropriate action is taken in response to every such incident including any requirements that are provided for in the regulations for investigating and responding.

3) Retrain all staff responsible for investigating abuse and/or neglect of a resident.

4) Maintain records of re-training, including who received the training, when it occurred, and what the content of the training included.

Grounds / Motifs :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident of neglect of a resident by the licensee or staff, that the licensee knew of, or that was reported to the licensee, was immediately investigated.

A complaint was submitted to the Director which alleged that, on an identified date, at specified time, resident #007 had care needs that were not completed. The complainant reported they were not sure if any of the residents attended an identified meal, or were provided with an identified meal and that residents were being neglected because of the staffing shortages in the home.

A Critical Incident System (CIS) report was submitted to the Director for the incident that occurred on an identified date. The report identified two alleged areas of neglect as: (1) resident #007 had been found with their care needs not completed at a specified time; (2) residents had not received an identified meal (resident #007 had not received the identified meal that date, eight other residents may not have received the same meal that date, and one resident had received a meal tray but had not been assisted to eat).

O. Reg. 79/10 defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and included inaction or a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A review of the home's policy, "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" revised April 2017, indicated that Extendicare had a zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated. The policy further indicated that all reported incidents of abuse and/or neglect would be objectively, thoroughly and promptly investigated.

Inspector #625 reviewed Clinical Manager #113's handwritten and typed notes from meetings with staff and family members conducted related to the incident on an identified date. The notes identified additional areas of alleged neglect including: (1) resident #016 had not received morning medications until a later time on an identified date; (2) resident #018 was required to be up for an identified meal at a specific time and was not out of bed until a later time, on an identified date; (3) on an identified date, resident #017's family member was overheard by an RPN state to the RN that they wished resident #017 would die as the resident was suffering and neglected; (4) on an identified date resident #007's family member had arrived at a specified time and observed that the resident had not received continence care since the previous night; and (5) resident #007 had to wait for up to 40 minutes for assistance at times, when their call bell was rung. The notes also identified the Clinical Manager had reviewed the Meal Consumption and Distribution Sheet to determine which residents had recorded intake.

Inspector #625 reviewed the Meal Consumption and Distribution sheet for a specific unit for an identified date, and noted that 32 out of 32 residents, or 100 per cent (100%) of residents on that specific unit, had blank and incomplete documentation for a specific hour fluid pass, and no staff person had recorded that the morning beverage pass had been completed including the actual time it was delivered, the name of the staff who delivered or the initials of the staff member who delivered the beverage pass.

A review of Dietary Reports for an identified date on a day shift, identified 22 out of 32, or 69 per cent, of residents had no documentation related to the offering or

provision of two identified meals or a specified nourishment pass; and 32 out of 32 residents, or 100 per cent, of the resident had no documentation related to a specified beverage pass.

During an interview with DOC #104, they acknowledged that allegations communicated to, or discovered by, the home's management when following up on the incidents that occurred on an identified date, were allegations of neglect that should have been investigated at the time they were identified. The DOC specifically identified the administration of morning medications being given at a later time to resident #016, and the Meal Consumption and Distribution sheet that was blank for all residents for the morning beverage pass, had not been investigated. [s. 23. (1) (a)]

2. A complaint was submitted to the Director which alleged that residents on a specific unit were found to have been incontinent overnight. The complainant further alleged that the incident had been reported to "administration"; they had been told that this incident had not required a report to the Ministry of Health and Long-Term Care.

During an interview with DOC #114, they confirmed that they and Clinical Manager #100 had received an email which described concerns from staff that residents on a specific unit had not received care during an identified round at a specified time on a specified date. The residents were found to be incontinent of urine on an identified shift, at a specified time. The DOC reported that RN #115, forwarded an email to them and Clinical Manager #100 regarding the care concerns.

Inspector #577 reviewed the email correspondence from RN #115, which outlined the following concerns from night staff:

- resident #020 was found 'soaking wet' from urinary incontinence upon completion of their round at a specified time; the previous shift had reported that they had changed resident #020 just prior to the time of the round;
- resident #023 was found to have been wearing their day incontinent product, and had not been placed in a night incontinent product;
- resident #024 was in bed and did not have their fall prevention strategies in place beside their bed;
- resident #021 did not have their specified intervention in place;

- resident #019 was placed into bed at an identified time and night staff found them positioned in the upright position; and
- resident #022 reported that the evening staff had offered to change their incontinent product but had not returned to their room; the evening staff reported to the night staff that resident #022 had been aggressive and had refused care.

The email further indicated that this had been an ongoing concern where some Personal Support Workers (PSWs) were failing to complete their last evening round and as a result, night staff were finding residents incontinent of urine.

During an interview with Clinical Manager #116, they reported that they had received a phone call from RN #117 on an identified date, at a specified time, who had reported that residents on a specific unit were found with care issues during the night, as outlined in the email. Clinical Manager #117 reported that they notified the Administrator at that time.

During an interview with Clinical Manager #100, they reported to Inspector #577 that they had received an email on an identified date, from RN #115 which described care concerns from the staff on a specific shift, on an identified date. They further reported that their investigation entailed the viewing of video footage in two hallways, from the evening of an identified date, over a specified time period and concluded that staff had entered residents rooms and performed care. They confirmed with the Inspector that their investigation did not include any interviews with residents and staff.

During an interview with Extendicare Regional Director #109, they confirmed that the allegations should have been investigated and should have included staff and resident interviews. [s. 23. (1) (a)]

3. Two complaints were submitted to the Director on two identified dates. The complaint alleged staffing shortages of Registered Practical Nurses (RPNs), Registered Nurses (RNs), and the home's expectation that RNs fill the role for medication administration, which was not generally performed by them. Twenty three "Professional Responsibility Workload Reporting Forms" (PRWRFs) were received by the home over a specific four month period.The "PRWRF's" indicated that there were shifts where RNs had to complete medication administration for the residents due to staffing shortages with RPNs, and some RPNs were not working to their full scope. The completed forms indicated that on occasion, the RNs were unable to

complete wound care treatments and other RN duties, which included assessments.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the 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.

Inspector #577 reviewed 23 "Professional Responsibility Workload Reporting Forms", and noted the following:

- on an identified date-there were multiple sick calls from RPNs on the day shift; three RNs were pulled to the medication cart on three different nursing units during the day shift; a resident had a change in their blood work where results were received at a specified time and the lab result had been passed onto an RN at an identified number of hours later, which had resulted in a delay in treatment;
- on that same date-eight complex wound care treatments were not completed on days or nights; and
- on another identified date-all scheduled wound care treatments were not done on days or nights.

Inspector #577 reviewed a letter dated on an identified date, in response to the "Professional Responsibility Workload Report", which had been addressed to the RNs from DOC #104. The letter acknowledged receipt of the "PRWRFs" dated on 12 identified dates; and that during those shifts they were short an RN as well as short RPNs for those shifts which required RNs to do the medication administration. The letter further acknowledged that working short had not provided the opportunity to have provided the care to the residents that should have been provided.

A review of the home's policy, "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-03", revised April 2017, indicated that all reported incidents of abuse and/or neglect would be objectively, thoroughly and promptly investigated.

During an interview with Clinical Manager #119, they reported to Inspector #577 that they had received the "PRWRF's" via email and they hadn't had any follow up with staff about care concerns documented on the forms.

During an interview with Clinical Manager #100, they reported that they had received the "PRWRF's" via email. They further reported that if care had not been completed, it was up to the nurse to communicate that to the next shift.

During an interview with Clinical Manager #116, they reported that the "PRWRF's" were received via email. They reported that when they had received the forms, they had not followed up or investigated whether the care was or was not completed.

During an interview with DOC #104, together with Inspector #577, the "PRWRF's" were reviewed specifically for two shifts on two identified dates. They reported that the forms were utilized as a workload issue and that there had been times when RNs were required to have completed medication administration. They further confirmed that they and the Managers had not followed up to determine whether care had not been provided. There were no investigation notes nor CIS reports completed. [s. 23. (1) (a)] (625)

2. A complaint was submitted to the Director which alleged that residents on a specific unit were found to have been incontinent overnight. The complainant further alleged that the incident had been reported to "administration"; they had been told that this incident had not required a report to the Ministry of Health and Long-Term Care.

During an interview with DOC #114, they confirmed that they and Clinical Manager #100 had received an email which described concerns from staff that residents on a specific unit had not received care during an identified round at a specified time on a specified date. The residents were found to be incontinent of urine on an identified shift, at a specified time. The DOC reported that RN #115, forwarded an email to them and Clinical Manager #100 regarding the care concerns.

Inspector #577 reviewed the email correspondence from RN #115, which outlined the following concerns from night staff:

- resident #020 was found 'soaking wet' from urinary incontinence upon completion of their round at a specified time; the previous shift had reported that they had changed resident #020 just prior to the time of the round;
- resident #023 was found to have been wearing their day incontinent product, and had not been placed in a night incontinent product;
- resident #024 was in bed and did not have their fall prevention strategies in place

beside their bed;
- resident #021 did not have their specified intervention in place;
- resident #019 was placed into bed at an identified time and night staff found them positioned in the upright position; and
- resident #022 reported that the evening staff had offered to change their incontinent product but had not returned to their room; the evening staff reported to the night staff that resident #022 had been aggressive and had refused care.

The email further indicated that this had been an ongoing concern where some Personal Support Workers (PSWs) were failing to complete their last evening round and as a result, night staff were finding residents incontinent of urine.

During an interview with Clinical Manager #116, they reported that they had received a phone call from RN #117 on an identified date, at a specified time, who had reported that residents on a specific unit were found with care issues during the night, as outlined in the email. Clinical Manager #117 reported that they notified the Administrator at that time.

During an interview with Clinical Manager #100, they reported to Inspector #577 that they had received an email on an identified date, from RN #115 which described care concerns from the staff on a specific shift, on an identified date. They further reported that their investigation entailed the viewing of video footage in two hallways, from the evening of an identified date, over a specified time period and concluded that staff had entered residents rooms and performed care. They confirmed with the Inspector that their investigation did not include any interviews with residents and staff.

During an interview with Extendicare Regional Director #109, they confirmed that the allegations should have been investigated and should have included staff and resident interviews. [s. 23. (1) (a)]
(577)

3. Two complaints were submitted to the Director on two identified dates. The complaint alleged staffing shortages of Registered Practical Nurses (RPNs), Registered Nurses (RNs), and the home's expectation that RNs fill the role for medication administration, which was not generally performed by them. Twenty three "Professional Responsibility Workload Reporting Forms" (PRWRFs) were received by the home over a specific four month period.The "PRWRF's" indicated that there were shifts where RNs had to complete medication administration for the residents

due to staffing shortages with RPNs, and some RPNs were not working to their full scope. The completed forms indicated that on occasion, the RNs were unable to complete wound care treatments and other RN duties, which included assessments.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the 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.

Inspector #577 reviewed 23 "Professional Responsibility Workload Reporting Forms", and noted the following:

- on an identified date-there were multiple sick calls from RPNs on the day shift; three RNs were pulled to the medication cart on three different nursing units during the day shift; a resident had a change in their blood work where results were received at a specified time and the lab result had been passed onto an RN at an identified number of hours later, which had resulted in a delay in treatment;
- on that same date-eight complex wound care treatments were not completed on days or nights; and
- on another identified date-all scheduled wound care treatments were not done on days or nights.

Inspector #577 reviewed a letter dated on an identified date, in response to the "Professional Responsibility Workload Report", which had been addressed to the RNs from DOC #104. The letter acknowledged receipt of the "PRWRFs" dated on 12 identified dates; and that during those shifts they were short an RN as well as short RPNs for those shifts which required RNs to do the medication administration. The letter further acknowledged that working short had not provided the opportunity to have provided the care to the residents that should have been provided.

A review of the home's policy, "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-03", revised April 2017, indicated that all reported incidents of abuse and/or neglect would be objectively, thoroughly and promptly investigated.

During an interview with Clinical Manager #119, they reported to Inspector #577 that they had received the "PRWRF's" via email and they hadn't had any follow up with

staff about care concerns documented on the forms.

During an interview with Clinical Manager #100, they reported that they had received the "PRWRF's" via email. They further reported that if care had not been completed, it was up to the nurse to communicate that to the next shift.

During an interview with Clinical Manager #116, they reported that the "PRWRF's" were received via email. They reported that when they had received the forms, they had not followed up or investigated whether the care was or was not completed.

During an interview with DOC #104, together with Inspector #577, the "PRWRF's" were reviewed specifically for two shifts on two identified dates. They reported that the forms were utilized as a workload issue and that there had been times when RNs were required to have completed medication administration. They further confirmed that they and the Managers had not followed up to determine whether care had not been provided. There were no investigation notes nor CIS reports completed. [s. 23. (1) (a)]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was actual harm. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
- on February 2, 2018, a Voluntary Plan of Correction (VPC) was issued during a Critical Incident System (CIS) Inspection #2018_657681_0001;
- on October 11, 2018, a VPC was issued during a CIS Inspection #2018_624196_0024;
- on October 11, 2017, a Written Notification (WN) was issued during a CIS Inspection #2017_509617_0017; and
- on October 11, 2016, a WN was issued during a Resident Quality (RQI) Inspection #2016_435621_0012.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 19, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 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. 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 or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be in compliance with s. 24 (1) of O. Reg. 79/10. Specifically the licensee must:

1) Retrain all direct care staff, registered staff and leadership, on the long term care home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make mandatory reports.

2) Protect all residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

3) Ensure all registered, non-registered and leadership staff identify and report all alleged, suspected and witnessed incidents of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, 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, immediately to the Director.

4) Maintain records of re-training, including who received the training, when it occurred, and what the content of the training included.

Grounds / Motifs :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident had occurred, or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

A complaint was submitted to the Director alleging that multiple residents in the home had not received an identified meal on an identified date.

The corresponding Critical Incident System (CIS) report identified that there was no documentation that resident #015 received an identified meal.

During a review of resident #015's progress notes, Inspector #625 read a progress note entered by RPN #110 which identified that, on an identified date, the resident had been found in their room set up and strapped into a specific device, while in their chair unattended, for an approximate amount of time. The note indicated that PSW

#120 had connected the apparatus to the specific device and then left the resident to find another staff member to assist with the transfer. A second progress note on an identified date, entered by RN #121 identified that the resident recalled the incident when assessed by the RN; the RN had contacted the home's Administrator on call and had received direction from the Administrator, who had consulted with Extendicare Assist, to complete a Safety Report and a hard copy of a critical incident form to assist with the internal investigation. The progress notes did not identify that the Director had been notified of the incident.

The Inspector reviewed Ministry of Health and Long-Term Care records and was not able to locate notification via the After-Hours Line or the Critical Incident System that the home had notified the Director of the incident.

The Extendicare PowerPoint in use in the home titled "General Orientation Safe Lifting with Care Program" (undated) indicated that, when using a mechanical lift, staff were required to ensure a second staff member was present and ready to assist and two staff correctly placed the sling. The PowerPoint also identified that all staff were to be knowledgeable of their specific roles and responsibilities in the use of mechanical lifts.

The Extendicare policy in use in the home, "Mechanical Life Procedure - LP-01-01-03", revised August 2017, identified that, for a sit-to-stand lift, staff were to remain with a resident during the entire time the sling was connected to the mechanical lift.

The Extendicare policy in use in the home, "Zero Tolerance of Resident Abuse and Neglect: Response and Reporting – RC-02-01-02", revised April 2017, included a document titled, "Jurisdictional Reporting Requirements – Appendix 2", revised April 2017, which identified that in Ontario, the LTCHA provided that any person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident, immediately reported the suspicion and the information upon which it was based to the Director of the Ministry of Health and Long-Term Care.

A review of the home's investigation file included:

- an email on an identified date, from the Administrator to DOC #104 and Clinical Manager #100, which indicated that the Administrator had received a call the

previous night regarding the incident and "It did not meet the criteria for a CIS" and needed to be investigated internally. The email thread included a forwarded email on an identified date, from RN #121 to the Administrator that identified resident #015 had been "left in error, strapped into the specific device in [their] room by the PSW for an identified amount of time;
- an email from PSW #120 on an identified date, forwarded by the Administrator to Clinical Manager #100 and copied to DOC #104 on an identified date, indicated that the PSW had strapped resident #015 into the specific device while the resident remained seated in their chair. The email read "Because I am aware of the policies regarding lifts I intended to briefly step out of the resident's room to quickly grab a colleague to assist me in the transfer" and that the resident remained seated in their chair clipped into the specific device for an identified amount of time. The PSW wrote that they had asked two PSWs for assistance with the transfer but neither had been able to assist, and that the second PSW had been providing care to a resident and had asked PSW #120 to begin the care of another resident in the meantime, until they were able to come to their aid. Resident #015 remained clipped to the specific device for an identified amount of time as the PSW had "…completely forgot because I was assisting with the HS care of other residents while I waited for help, this was my mistake";
- a safety report which contained details consistent with those entered in the progress notes. The safety report contained the question "Was the patient or could the patient have been harmed?", and the corresponding response "True"; and
- a letter dated on an identified date, from DOC #104 to PSW #120 that identified the details of the incident which were consistent with the PSW's emailed account, and read "…in discussion you were not aware that part of the Safe Lifting with Care Program included that prior to applying a sling both staff that will be providing the lift needs to be present".

During an interview with RPN #110 they stated that resident #015 had been connected to a specific device by an apparatus, with no shoes on their feet, with their chair up close to the device, for an identified amount of time. The RPN stated that the resident had a specific medical impairment and required two staff to have been present for assistance with transfers for the specific device. The RPN stated that PSW #120 had left the resident connected when they went "a far distance" from the resident to find help with the transfer. The RPN stated that the home's training required two staff to be present to apply transfer apparatus' to residents, to ensure the apparatus' were correctly applied, to reduce the risk that the apparatus was

improperly positioned and that the resident would fall out, but that PSW #120 had applied the apparatus alone. The RPN identified multiple ways the incident had put the resident at risk of harm. The RPN stated that they recalled that RN #121 had phoned the Administrator and asked them if the incident was reportable to the MOHLTC. The RPN stated that they did not know what the Administrator told the RN but the RPN thought "for sure it was reportable" and that they thought that the Director would have been notified.

During an interview with RN #121 they confirmed that resident #015 had been left in an apparatus connected to a specific device for an identified amount of time. The RN indicated that leaving a resident in an apparatus, connected to a specific device, unattended for an identified amount of time was not providing proper care to the resident. The RN also indicated that the home's policy, which required staff to remain with residents the entire time the apparatus was connected to the specific device, had not been followed. The RN stated they had phoned the Administrator, who then consulted with Extendicare Assist [third party management in the home] and phoned the RN back with direction, which included completion of an internal safety report and a hard copy critical incident report. The RN stated that they had specifically asked the Administrator if they needed to complete an online critical incident report to notify the Ministry but that the Administrator told the RN that it was not within the RN's purview to do so. The RN stated that they were not directed to notify the Director/Ministry, no one told the RN to phone it in, and the RN stated "I just did what I was told".

During an interview with DOC #104, they acknowledged that resident #015 had been connected by an apparatus to a specific device for an identified amount of time without staff present. The DOC stated that the incident had been discussed during a management meeting that was held the Monday following the incident [the day after the incident occurred], where the home's Administrator, DOCs and Clinical Managers were present, but that the incident had not been reported to the Director. The DOC stated that the incident was a mistake, that the resident had not been harmed and that "ideal care" had not been provided. The DOC identified that the resident should not have been left unattended while connected to the specific device for an identified amount of time.

During an interview with Extendicare Regional Director #109, they stated that they were familiar with the incident as the Administrator had consulted with them when the

incident happened. The Regional Director stated the Administrator described the incident as "low risk" and said there had been no risk of harm to the resident. The Regional Director stated they asked clear questions about the risk and harm to the resident and they would have needed to have full information and be fully apprised of what happened to determine if there had been a risk of harm. They stated the Administrator had formed the opinion that it was incompetent care, the PSW had not followed the policy for lifts and transfers, it was not intentional and the PSW had not intended to leave the resident unattended. The Regional Director stated if there was a risk of harm to the resident, the incident would have been reported to the Director, but the Regional Director reiterated that the Administrator had informed them that the resident had not been at risk during the incident.

During an interview with the Administrator, they stated they were aware that the resident had been connected to a specific device while in a chair in their room, that a PSW put the resident in the apparatus attached to the specific device, went to look for help and didn't come back for quite some time. The Administrator acknowledged that the PSW had not followed the PowerPoint safe lift training presentation that identified two staff were required to apply the apparatus, as well as failed to follow the policy which identified the resident was not to be left unattended when connected to the specific device by the apparatus. The Administrator stated they told the RN that they would make a decision on whether or not to report it to the Director and would get back to the RN. They stated they then called the Extendicare Regional Director and talked it out and talked it through, following which they determined the incident didn't fit the description of incompetent care for reporting.

Further in the same interview the Administrator elaborated that the incident was not intentional and resulted from a mistake, and stated repeatedly that they did not believe that improper or incompetent care had been provided, but that two staff should have been present and the policy had not been followed. The Administrator stated they contacted the RN back, who was "fairly new" and told them that they didn't need to call the After-Hours number to report the incident, but that they were to complete a paper critical incident report. The Administrator stated that there was a risk of harm occurring to the resident as the resident "wasn't able to get out", but repeatedly identified that the incident had not been reported to the Director, as improper or incompetent care had not occurred. [s. 24. (1) 1.]
(625)

2. A complaint was submitted to the Director regarding resident #002 who had

experienced an incident and the care provided after the incident. The complainant alleged the resident had an injury on an identified area of their body, had been administered a specific medication within a half an hour after the injury, and the residents health subsequently declined; the incident had not been reported to the Ministry of Health and Long-Term Care (MOHLTC).

An additional complaint was submitted to the Director regarding this same incident involving resident #002. The complainant had concerns regarding the care provided after the incident, the administration of a specific medication after the incident, and the decline in the resident's condition afterward.

The licensee's policy, "Mandatory and Critical Incident Reporting (ON) RC-09-01-06", revised April 2017, indicated the following:

- the home would report and submit all Mandatory and Critical Incidents to the Ministry of Health and Long Term Care, within the required timeframes, in accordance to the Ontario Long Term Care Homes Act, 2007;
- the Director of Care /Designate were required to inform the MOH Director immediately, in as much detail as was possible in the circumstances of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; and
- make a report immediately following an incident, and if it was after normal business hours, report using the Ministry's method for after-hours emergency contact.

Inspector #196 reviewed the health care records for resident #002. A progress note on an identified date, indicated resident #002 had an incident in a specific area of the home which had been witnessed by non-staff members. The witnesses stated that the resident was trying to give way to someone and the resident traveled on an uneven area, and experienced an incident. The notes indicated the Substitute Decision Maker (SDM) and the Physician was notified. In addition, the notes contained the details of an assessment that was conducted, and the initiation of a specific routine.

A progress note on an identified date, with a particular focus, indicated a particular assessment of the resident was conducted at an identified approximate time. Findings included a specific injury to the resident, and a particular assessment with a specific numeric scale. The note also identified that Physician #122 was notified at

an identified time regarding resident #002's current condition; that the MD had been made aware of the incident the previous evening; however, the incident had been described to them as the resident had slid from their mobility aid; and it had been mistakenly reported to them last evening that the resident was not on a specific medication. In addition, the progress note provided clarification that the resident was taking a specific medication and that Physician #122 could not differentiate at that time whether the resident's symptoms were from their specific medical condition or possible specific injury from the incident. The electronic medication administration record (eMAR) identified that a specific medication had been administered twice daily at specific times the weeks previous to the fall. In addition, a dose was recorded as administered at an identified time on an identified date, approximately one half hour after the incident. A particular assessment , as in MED e-care, was completed on an identified date, and did not identify that the resident was currently on a specific medication; although, there was an option to have selected the specific medication on the assessment.

The investigation file for the resident's incident on an identified date, was reviewed. The homes' internal incident report identified that the incident had occurred at an approximate time on an identified date. The hand written notes from the video review of the resident's incident indicated that it had appeared that the resident may have hit an identified area of their body.

During an interview with RPN #123, they confirmed they had worked the night of resident #002's incident. They reported the resident was trying to get out of the way of another resident and experienced an incident where they had injured an identified area on their body. They further reported that the RN had administered a specific treatment on an identified area on their body. When asked by the Inspector whether the resident was taking a particular medication or if they had administered the particular medication to the resident after the fall they reported that after a fall, they usually held a particular medication, but couldn't recall that it wasn't given that shift.

During an interview with RN #124, they reported that they were working on the shift when resident #002 had experienced an incident and stated bystanders said that the resident may have hit an identified area of their body. RN #124 had spoken to Physician #122 and reported the resident had an incident and had told the physician that they may have hit an identified area of their body and could not recall telling the physician that they were or were not on a particular medication. They further reported

to the Inspector they didn't know the resident was taking a particular medication.

During an interview with RN #125, they reported to the Inspector that they had spoken to Physician #122 and the physician had said they did not know that the resident was on a particular medication, and that the resident's incident had been described as a slide out of the mobility aid. The RN further reported that they had a discussion with Clinical Manager #100 regarding the particular medication that had been given after the incident, the significant change in the resident's condition and whether this should be reported to the MOHLTC. The RN then reported that the Administrator had stated that they had spoken to the MOHLTC and said the incident was not reportable.

During an interview with Clinical Manager #100, they confirmed that they had reviewed the video of resident #002's incident the following day and had made hand written notes of the review that were within the investigation file and notes from a discussion with Physician #122. They reported to the Inspector, that Physician #122 had not been informed that the resident took a particular medication when the incident had first been reported to them, and had not been informed that the particular medication had been administered to the resident approximately one half hour after the incident. They further reported, after talking with Physician #122 the day after the incident, the physician would have sent the resident to the hospital had they known the resident had hit an identified area of their body.

During a further interview with Clinical Manager #100, they reported that they had received direction from the Administrator to not report this incident to the Director at the MOHLTC.

Together with the Inspector, DOC #104, reviewed the progress note documented on an identified date, at a specified time, by RN #125. During discussion of the progress note, which included the mechanism of the resident's incident; the Physician being unaware that the resident was on a particular medication; and that the particular medication being given approximately a half hour after the incident, DOC #104 acknowledged that this could have been reported as incompetent care based upon this information.

During an interview with Extendicare Regional Director #109, they reported that their process included the Administrator to have contacted the Extendicare Regional

Director to inform of areas of resident risk, or potential risk. They added that Hogarth Riverview Manor was a home in their portfolio; and they had not been informed of this incident until the week of the inspection, during the time that the Inspector was speaking to the DOC. They further confirmed that they would have provided direction to report to the Director MOHLTC, for improper care, based upon the information known. [s. 24. (1) 1.]
(196)

3. The licensee has 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 occurred or may have occurred, immediately reported the suspicion and the information upon which it was based to the Director.

According to the Long-Term Care Homes Act, 2007 O. Reg 79/10, s.5, neglect is defined as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

A complaint was submitted to the Director which alleged that residents on a specific unit were found to have been incontinent overnight. The complainant further alleged that the incident had been reported to administration, and had been told that this incident did not require a report to the Ministry of Health and Long-Term Care.

Refer to WN #1-finding #2 for further details.

During an interview with DOC #114, they confirmed that they and Clinical Manager #100 had received an email which described concerns from staff that residents on a specific unit had not received care rounds during a specified round on an identified date. The residents were found to be incontinent of urine on a specified shift. They further reported that RN #115 had forwarded an email to them and Clinical Manager #100 regarding the care concerns.

A review of the home's policy, "Extendicare-Zero Tolerance of Resident Abuse and Neglect Program – RC-02-01-01" revised April 2017, indicated that Extendicare had a zero tolerance for abuse and neglect. Any form of abuse or neglect by any person, whether through deliberate acts or negligence, would not be tolerated. The policy further indicated that anyone who suspected or witnessed neglect that caused or

may cause harm to a resident was required to contact the Ministry of Health and Long Term Care.

A review of the homes policy, "Extendicare-Mandatory and Critical Incident Reporting – RC-09-01-06", revised April 2017, indicated that the home was to inform the MOH Director immediately, in as much detail as was possible, improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident; mandatory reporting under the LTCHA, section 24(1) of the LTCHA required a person to make an immediate report to the Director where there was a reasonable suspicion that certain incidents occurred or may occur: improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

During an interview with Clinical Manager #100, they reported that they had received an email on an identified date, from RN #115 which described care concerns brought forward by the staff working a specified shift on an identified date. They reported that the On-call Manager #116 had received a phone call from RN #117 on the morning of an identified date, who reported that residents on a nursing unit were found with care issues. They further reported that these concerns were not reported to the Ministry of Health and Long-Term Care as the Administrator stated it was performance issues with staff, it would be an internal investigation and would not be reported to the Ministry.

During an interview with Clinical Manager #116, they reported to Inspector #577 that they were the On-call Manager on an identified date, and had received a phone call from RN #117 at a specified time, who had reported that residents on a specific unit were found with care issues during a specified shift, as outlined in the email. Clinical Manager #116 reported that they notified the Administrator, who directed them that these were performance issues with staff and directed them not to report it to the Ministry as no one was harmed.

During an interview with DOC #114, they reported they were aware of the reporting requirements and had been directed by the Administrator to not report this incident to the Ministry.

During an interview with Extendicare Regional Director #109, they confirmed with Inspector #577 that the resident care concerns that were documented in the email should have been reported to the Director. [s. 24. (1) 2.]

(577)

4. Two complaints were submitted to the Director on two identified dates, which alleged staffing shortages of RPNs and RNs.

Refer to WN #1-finding #3, for details.

O. Reg. 79/10 defines neglect as the failure to provide a resident with the 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.

Inspector #577 reviewed 23 "Professional Responsibility Workload Reporting Forms", and noted the following:

- on an identified date-there were multiple sick calls from RPNs on the day shift; a resident had a change in their blood work where results were received at an identified time and passed onto an RN at a specific number of hours later, which had resulted in a delay in treatment;

- on that same date-eight complex wound care treatments were not completed on days or nights; and

- on another identified date-all scheduled wound care treatments were not done on days or nights.

Inspector #577 reviewed a letter regarding "Professional Responsibility Workload Report Forms" dated on an identified date, addressed to the RNs from DOC #104. The letter acknowledged receipt of the "PRWRFs" dated on 12 identified dates; and that during those shifts they were short an RN(s) as well as short RPNs for those shifts which required RNs to do the medication administration. The letter further acknowledged that working short had not provided the opportunity to have provided the care to the residents that should have been provided.

During an interview with RN #125, they reported that they had submitted "PRWRFs" because wound care treatments weren't being completed as ordered, there were delays in completing assessments, and RNs were required to have completed medication administration when the home was short staffed for RPNs.

During an interview with RN #126, they reported that they had submitted "PRWRFs", as frequently the RNs were required to have completed medication administration when the home was short RPNs, and there were times when wound care treatments and/or assessments would not be completed.

During an interview with RN #127, they reported that when the home had been short in their complement of RPNs, the RNs were responsible for medication administration, and daily wound care treatments were not being completed.

During an interview with RN #128, they reported the main concern for submitting "PRWRFs" was related to the home's requirement that RNs complete medication administration when the home had been short RPNs and wound care treatments had not been completed as ordered and would have been missed for a few days.

During an interview with Clinical Manager #119, they reported to Inspector #577 that they had received the "PRWRFs" via email and they hadn't had any follow up with staff related to the care concerns documented on the forms as it's a union tool related to workload.

During an interview with Clinical Manager #100, they reported that they had received the "PRWRFs" via email. They reported that if care was not completed, it was up to the nurse to communicate it to the next shift.

During an interview with Clinical Manager #116, they reported that the "PRWRFs" were received via email. They reported that when they had received the forms, they had not followed up or investigated whether the care was or was not completed.

During an interview with DOC #104, together with Inspector #577, reviewed the "PRWRFs", specifically for two shifts on two identified dates. They reported that the forms were utilized as a workload issue and that there had been times when RNs were required to have completed medication administration. They further confirmed that they and the Managers had not followed up to determine whether care had not been provided, nor was it reported to the Director. [s. 24. (1) 2.]
(577)

5. A complaint was submitted to the Director which alleged that, on an identified date, at a specified time, resident #007 had care needs that were not completed. The

complainant reported they were not sure if any of the residents were provided with an identified meal on an identified date. The complainant identified that the specific unit had been operating with less staff than the usual scheduled staff complement due to sick calls and stated that residents were being neglected because of the staffing shortages in the home.

Refer to WN #1-finding #1, for details.

Inspector #625 reviewed an after hours phone call report submitted by the home on an identified date, for an incident that occurred five days prior, on an identified date. The log identified that improper care had occurred as residents #007, #009, #010, #011, #012, #013, #014 and #015, all missed an identified meal as reported by family.

A CIS report was submitted to the Director on an identified date, for the incident that occurred on an identified date. The report identified that:

- on an identified date, resident #007's family member had informed Clinical Manager #113 that a specific unit had been short one PSW during a specified time frame and resident #007 had care needs that were not completed at an identified time;
- on the following day, three family members met with DOC #104 and Clinical Manager #113 and resident #017's family member reported eight residents had not received a specific meal on an identified date;
- on the day after that, RPN #129 informed Clinical Manager #113 that resident #011 had received a tray but had not been assisted to eat a specific meal; and
- two days later, a review of the investigation conducted with the home's management team determined that, based on the family member's account [documented in the report as provided] several of the residents may have missed the identified meal, and the incident was called in to the MOHLTC after hours number.

Inspector #625 reviewed Clinical Manager #113's notebook and identified entries related to the incident on an identified date, as follows:

- on an identified date, during a meeting with Clinical Manager #113, resident #007's family member detailed allegations of care needs that were not completed . The notes also identified the resident would have to wait for up to 40 minutes for assistance when their call bell was rung;

- on that same identified date, the Clinical Manager spoke with PSW #130 who stated resident #017's family member reported that eight residents had not received an identified meal, but that the PSW believed possibly four residents had not received an identified meal;
- the following day, Clinical Manager #113 and DOC #104 met with resident #007, #016 and #017's family members who shared various concerns about the incidents on an identified date, including that resident #016 received morning medications at a later time, that eight specific residents had not had an identified meal, that resident #018 required another specified meal at a specified time and was not out of bed until a later time; and
- on an identified date, Clinical Manager #113 met with RPN #129 who stated that, on an identified date, resident #011 did not get to eat due to "timing/staffing" and that they overheard resident #017's family member state to the RN that they wished the resident would die as the resident was "suffering here/neglect".

A review of typed notes in the home's investigation file included details consistent with those in the notebook. The typed notes elaborated on a comment made on an identified date, shared with Clinical Manager #113 by RPN #129 on an identified date, that resident #017's family member said to RN #126 they wished the resident "would die because [they are] suffering here and being neglected".

During an interview with DOC #104, they acknowledged that allegations communicated to the home's management about the incidents that occurred on an identified date, were allegations of neglect that should have been reported to the Director at the time that they were identified. [s. 24. (1) 2.]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was harm/risk. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
-a Written Notification (WN) was issued during a Critical Incident System (CIS) Inspection #2017_509617_0017 on October 11, 2017;
-a Voluntary Plan of Correction (VPC) was issued during a Resident Quality (RQI) Inspection #2017_624196_0005, on May 16, 2017;
-a VPC was issued during a CIS Inspection #2017_616542_0003, on February 9, 2017; and
-a VPC was issued during a RQI Inspection #2016_435621_0012, on October 11,

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

2016.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 19, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be in compliance with s. 48. (1) (2) of O. Reg. 79/10. Specifically the licensee must:

a) Conduct an audit of all of the residents in the home requiring weekly wound assessments by registered nursing staff.

b) Complete a weekly wound assessment of the residents' wounds, utilizing the "Bates-Jensen Wound Assessment" or "Impaired Skin Integrity Assessment" as required.

c) Complete the "Wound Assessment Tool" with accurate documentation with every dressing change.

d) Document the treatment regime on the Electronic Medication Administration Record (eMAR) with every dressing change.

e) Establish an auditing routine to ensure that weekly wound assessments are being completed.

f) Establish an auditing routine to ensure that the "Wound Assessment Tool" and the eMAR are being completed with every dressing change.

g) Maintain records of the actions taken with respect to the above items.

Grounds / Motifs :

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

Two complaints were received by the Director on two identified dates, which alleged staffing shortages of RPNs and RNs. Twenty three "Professional Responsibility Workload Reporting Forms" (PRWRF) were received by the home over an identified four month period. The completed forms indicated that on occasion, the RNs were unable to complete wound care treatments and other RN duties, which included assessments.

Inspector #577 reviewed 23 "Professional Responsibility Workload Reporting

Forms", and noted the following:

- on an identified date-there were multiple sick calls from RPNs on the day shift; three RNs were pulled to the medication cart on three different nursing units during the day shift;
- on that same date-eight complex wound care treatments were not completed on days or nights; and
- on an identified date-all scheduled wound care treatments were not done on days or nights.

Inspector #577 reviewed the 'RN Report' sheets for two identified dates, which indicated that four residents required daily treatments to have been completed by an RN.

A review of the home's "Skin and Wound Program: Wound Care Management - RC-23-01-02", revised February 2017, indicated that staff were to document all skin breakdown in the progress notes and surveillance tools, complete the "Bates-Jensen Assessment" every 7 days for pressure ulcers/venous stasis or ulcers of any type; complete the "Impaired Skin Integrity Assessment" for all other skin impairments, and record the treatment regimen on the Electronic Medication Administration Record (eMAR) and/or Electronic Treatment Administration Record (eTAR).

During an interview with Clinical Manager #116, they reported to Inspector #577 that staff were required to document their treatments on the eMAR and a particular assessment record for altered skin integrity with each treatment.

During an interview with Clinical Manager #100, they reported that staff were required to document treatments on the eMAR, and on a particular assessment record for altered skin integrity with every treatment. They further reported that if there wasn't any documentation in those two areas, then the treatments hadn't been done. They further reported that that the another particular assessment record was the clinical tool utilized for weekly assessments for a specific type of altered skin integrity.

During an interview with RPN #131, they reported that registered staff were required to have documented on the eMAR and on a particular assessment record for altered skin integrity with every treatment. They further reported that weekly documentation

was required on two other particular assessment records for two specific types of altered skin integrity.

During an interview with RPN #132, they reported that staff were required to have documented on a particular assessment record and the eMAR with every treatment.

a) Inspector #577 reviewed resident #004's treatment orders on an identified date, following a medical intervention. The resident had required daily treatments for two areas of altered skin integrity.

In a review of resident #004's particular assessment record for altered skin integrity, over an identified three month period, Inspector #577 identified daily treatments were not documented on the following days:
-five days for an identified month, for one area of altered skin integrity;
-seven days for an identified month, for another area of altered skin integrity;

-12 days for an identified month, for one area of altered skin integrity;
-11 days for an identified month, for another area of altered skin integrity;

-13 days for an identified month, for one area of altered skin integrity;
-15 days for an identified month, for another area of altered skin integrity;

In a review of resident #004's eMAR over an identified three month period, the Inspector identified daily treatments were not documented on the following days:
-13 days for an identified month, for an area of altered skin integrity;
-18 days for an identified month, for another area of altered skin integrity;

-14 days for an identified month, for an area of altered skin integrity;
-22 days for an identified month, for another area of altered skin integrity;

-12 days for an identified month, for an area of altered skin integrity;
-22 days for an identified month, for another area of altered skin integrity.

A review of another particular weekly assessment for resident #004, revealed a gap of 21 days, for an identified month, where there were no weekly assessments completed; missing weekly documentation for a week in another identified month;

and a gap of 15 days and the last week in the next identified month where there were no weekly assessments completed.

b) Inspector #577 reviewed resident #008's treatment orders for an area of altered skin integrity, where they required daily treatment. An additional order for another area of altered skin integrity required treatment three times per week.

In a review of resident #008's particular assessment record for altered skin integrity, over an identified three month period, Inspector #577 identified daily treatments were not documented on the following days:
-11 days for an identified month, for one area of altered skin integrity;
-11 days for an identified month, for another area of altered skin integrity.

In a review of resident #008's eMAR, over an identified three month period, Inspector #577 identified daily treatments were not documented on the following days:
-10 days for an identified month, for one area of altered skin integrity;
-documented once for the first and third week of an identified month, for another area of altered skin integrity;

-11 days for an identified month, for one area of altered skin integrity;
-documented once for the first week, and twice for the second and fourth weeks of an identified month, for another area of altered skin integrity;

In a review of the eMAR for an identified month, Inspector #577 identified treatment orders for an area of altered skin integrity had changed to three times per week; and were documented twice for the first week, no documentation for the second week, and once for the third and fourth week of an identified month;
-documented once for the third and fourth week, and no documentation for the second week of an identified month, for another area of altered skin integrity.

A review of another particular weekly assessment for resident #008, revealed a gap of 36 days between two identified months, where there were no weekly assessments completed; a gap of 18 days for another identified month, where there were no weekly assessments completed.

c) Inspector #577 reviewed resident #006's treatment orders for an area of altered

skin integrity, where they required a particular treatment three times a week and another treatment daily.

In a review of resident #006's particular assessment record for altered skin integrity, over an identified three month period, Inspector #577 could not determine when the treatment was completed. The documentation was inconsistent and the Inspector found 42 of 53 days or 80 per cent of the time, the assessment record had not indicated that treatment was completed, as was required.

In a review of resident #006's Emar for an identified month, Inspector #577 identified that treatments had been documented once for the first week.

In a review of resident #006's Emar for an identified month, Inspector #577 identified that treatments had been documented once for the third week, and no documentation for the second and fourth week.

In a review of resident #006's Emar for an identified month, Inspector #577 identified that treatments had been documented once for the first and fourth week, and no documentation for the second and third week.

During an interview with DOC #104, they reported to Inspector #577 that staff were required to have documented on the eMAR and a particular assessment record with every treatment; another particular assessment record was required once a week for wound ulcers and another particular assessment record for skin tears. DOC #104 and the Inspector reviewed the incomplete documentation for residents #004 and #008, over an identified four month period. The DOC confirmed that staff had been inconsistent with their skin assessment documentation. They further confirmed that the treatments were not completed if it wasn't documented both on the eMAR and a particular assessment record and staff had not implemented or followed the Wound Program.

During an interview with DOC #114, they reported to Inspector #577 that staff were required to have documented on the eMAR and a particular assessment record with every treatment. DOC #114 and the Inspector reviewed the incomplete documentation for resident #006 over an identified three month period. They confirmed that staff had been inconsistent with their assessments and

documentation, and it had been unclear when staff had completed the particular assessment. [s. 48. (1) 2.]

The decision to issue this Compliance Order (CO) was based on the scope which was widespread, the severity which was minimal harm or minimal risk. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation, as follows:
-a Voluntary Plan of Correction (VPC) was issued during a Complaint Inspection #2018_624196_0030, on December 20, 2018.
(577)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
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 de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

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

Issued on this 14th day of August, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by SYLVIE BYRNES (627) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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