Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7

Bureau régional de services de Hamilton
119 rue King Ouest 11iém étage
HAMILTON ON L8P 4Y7

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

Telephone: (905) 546-8294
Facsimile: (905) 546-8255

Téléphone: (905) 546-8294
Télécopieur: (905) 546-8255

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
Jun 27, 2019	2018_570528_0002 (A4)	005152-18	Complaint

M1

Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Fox Ridge Care Community
389 West Street BRANTFORD ON N3R 3V9

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

Amended by CYNTHIA DITOMASSO (528) - (A4)

Amended Inspection Summary/Résumé de l'inspection modified

Edits to Public report

Issued on this 27th day of June, 2019 (A4)

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

Original report signed by the inspector.

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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): September 11, 12, 13, 14, 17, 18, 19, 20, 21, 25, 26, 27, 28, and October 1, 2, 3, 2018

This Complaint Inspection was completed concurrently with Resident Quality Inspection log # 023251-18 and Critical Incident System Inspection log # 01640618.

Non-complaince related to O. Reg. 79/10 s. 50(2) identified during inspection of complaint log # 011543-17, (completed concurrently with RQI log #023251-18) is included in this inspection report and has been issued as a Compliance Order.

Non-compliance related to LTCHA s. 19(1) identified during RQI log # 023251-18 is included in this inspection report and is issued as a compliance order.

Non compliance related to LTCHA s. 6(4) and (5) identified during this inspection, was included in RQI report #2018_543561_0016 and issued as a voluntary plan of correction.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), Office Manager, Nurse Practitioner, physicians, Unit Scheduling Coordinator,

Resident Relations Coordinator (RRC), Resident Assessment Indicator (RAI) Coordinator, registered nurses, registered practical nurses, personal support workers, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documents including but not limited to: staffing schedules, medical records, bathing schedules, complaints and concerns logs, meeting minutes, staffing schedules, and policies and procedures.

The following Inspection Protocols were used during this inspection:

Pain

Personal Support Services

Prevention of Abuse, Neglect and Retaliation

Reporting and Complaints

Skin and Wound Care Sufficient

Staffing

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

9 WN(s)

3 VPC(s)

6 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 nonrespect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care
Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that, (b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

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

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

The Ministry of Health and Long Term Care, received a complaint in March 2018, related to skin and wound care. According to the complainant, the home failed to assess the resident leading to an area of altered skin integrity.

i. Review of the plan of care revealed that in 2018, resident #018 was admitted to the home with altered skin integrity. Several days after admission, the Point of Care (POC) record identified that the resident had new altered skin integrity. A progress note also revealed that the family of the resident notified registered staff of the areas . ii. Review of the plan of care did not include a skin assessment, by a member of the registered nursing staff using a clinically appropriate assessment instrument, until eleven days after the new area of altered skin integrity was initially documented. At which time, the altered skin integrity had changed. iii. Interview with the Director of Care, confirmed that registered staff did not complete an assessment at the time the altered skin integrity was identified. (528)
PLEASE NOTE: This area of non-compliance was identified during a Complaint Inspection, log #005152-18, which was conducted concurrently during the

Resident Quality Inspection (RQI) log #023251-18. [s. 50. (2) (b) (i)]

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

The Ministry of Health and Long Term Care, received a complaint in March 2018, related to related skin and wound care. According to the complainant, the home failed to assess resident resulting in altered skin integrity.

i. Review of the plan of care for resident #018 identified that in 2018 the resident had altered skin integrity. Review of the treatment administration record (TAR), did not include immediate treatment and interventions to promote healing, until several days after the the altered skin integrity was identified.
b. Interview with the Director of Care, confirmed that resident #018 did not receive immediate skin and wound care treatment, as required in the home's Skin and Wound Care Program. (528)

ii. Resident #018 was admitted to the home with altered skin integrity. On the skin and wound admission assessment and in admission progress notes, registered staff documented altered skin integrity.
a. Review of the the electronic Treatment Administration Record (eTAR) did not include any treatment orders to one of the areas until 21 days after admission, when the family brought concerns forward related to infection
b. Review of the electronic Treatment Administration Record did not include any treatment plan for another area of altered skin inteigrty.
c. Interview with the Wound Care Lead #148, confirmed that the eTARS for resident #018 did not include immediate treatment and interventions to reduce pain, promote healing and prevent infection for areas of altered skin integrity.
(528)

PLEASE NOTE: This area of non-compliance was identified during a Complaint Inspection, log #005152-18, which was conducted concurrently during the

Resident Quality Inspection (RQI) log #023251-18. [s. 50. (2) (b) (ii)]

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

The Ministry of Health and Long Term Care, received a complaint in June 2017, related to skin and wound care. According to the complainant, the resident had altered skin integirty.

i. Review of the plan of care for resident #020, identified that they had recurrent areas of altered skin integrity and directed staff to monitor for signs and symptoms of infection.

ii. In May 2017, the skin and wound assessment identified a new area of altered skin integrity. Review of the plan of care did not included weekly assessments over several weeks, at which time, family brought concerns forward of infection. iii. Interview with the ADOC confirmed that the registered staff did not complete a weekly assessment of resident #020's altered skin integrity for one week until the family brought forward concerns related to infection. (528)

PLEASE NOTE: This non-compliance was issued related to Complaint Inspection log # 011543-17, completed concurrently with Resident Quality Inspection log #023251-18. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A4)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services
Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

(A2)
1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation).

The Ministry of Health and Long Term Care, received a complaint in March 2018, related to care concerns for a resident. In a follow up call with the complainant, during the course of the inspection, they identified concerns that home worked short staffed and they felt it contributed to neglect of the resident.

A. The LTC Homes Inspector #528 requested a list of shortages from the home. A list provided by the Unit Scheduling Clerk, outlining RN shortages from July to September 2018, was reviewed and revealed that the home operated without a registered nurse in the building approximately 28 times on evening shift and 27 times on night shift over the three month period.
i. Interview with the Unit Scheduling Clerk, confirmed that the home worked without a registered nurse in the building as outlined on the RN Shortages List and also revealed that the home had staff members off over the last few months; and therefore, were unable to fill absences in the schedule. They also confirmed that if an RN could not be replaced an RPN was called in for the shift. ii. Interview with the ED and DOC confirmed that they had one staff member return and have hired a part time RN to meet legislative requirements, but acknowledged that recruitment and retention was an ongoing concern and challenge. (528) PLEASE NOTE: This non-compliance was issued as a result of complaint inspection #005152-18, which was completed concurrently with the Resident Quality Inspection log #023151-18. [s. 8. (3)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
(A2)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect
Specifically failed to comply with the following:

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

Findings/Faits saillants :
(A1)
1. The licensee failed to ensure that residents were not neglected by the licensee or staff.

A. The Ministry of Health and Long Term Care, received a complaint in March 2018, related to care concerns for a resident in the home. According to the complainant, the home neglected to manage the resident's pain or care for the resident's areas of skin breakdown.

For the purposes of the Long-Terms Care Homes Act, 2007 and Ontario Regulation 79/10, 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 and well-being of one or more residents.

i. Review of the medical records revealed that in 2018 resident #018 was admitted to the home. Review of the Minimum Data Set Home Care Assessment indicated in 'Section Notes' that resident had specific diagnosis. Due to deterioration in mobility and cognition, the resident was no longer able to manage their own activities of daily living. The MDS Home Care Assessment also identified that the resident required care to altered skin integrity, medical treatment of specified symptoms and assistance with daily activities. ii. The plan of care was reviewed and identified the following inaction:

a. The MDS Home Care Assessment and admission skin and wound care assessment, identified that the resident was admitted to the home with an area of altered skin integrity requiring care. Interview with the Wound Care Lead #148 confirmed that a treatment plan was not established for the area until family had concerns of infection, three weeks later.

b. Review of an admission progress note identified that the resident had an additional area of altered skin integrity. Nine days later, registered staff documented

that they were applying treatment but, interview with the Wound Care Lead #148 confirmed, that the plan of care did not include a treatment plan until several days later.

c. Several days after admission, Point of Care documentation, revealed the resident had a new area of altered skin integrity; however, an initial skin and wound assessment, using a clinically appropriate tool, was not completed for several days. At which time, the area was documented as showing signs of infection.

d. Although the resident's plan of care included documented pain on the eMARS and the resident was described as showing symptoms of pain or discomfort in the progress notes, a comprehensive pain assessment was not completed in Point Click Care, as required by the home's 'Pain and Symptom Management' policy, confirmed in an interview with the ADOC. Furthermore, additional pharmacological pain interventions were not implemented until two days before the resident was discharged.

e. Review of the progress notes confirmed that registered staff documented that the family of resident #018 had ongoing care concerns of the resident. The

home did not investigate these concerns according to their Reporting and Complaints Procedure, as confirmed with an interview with the DOC.

f. Review of physician order history confirmed that the resident the plan of care did not reflect pre-admission diagnosis.

g. The home's policy "Palliative Care - Care of the Resident", revised January 2015, identified that all palliative residents should have comprehensive assessments and a current, up to date, plan of care. The procedure included directions included coordination of an interdisciplinary care conference to discuss changes in residents condition and advanced care planning. A care conference was held a day before the family had requested the resident be transferred. Interview with the RAI-MDS Coordinator confirmed that the care conference was held days before the resident had left the facility. iii. As a result of the pattern of inaction related to the the failure to complete comprehensive pain assessments, skin and wound assessment, and treatment plans, resident #018's health and wellbeing was jeopordized and they were not protected from neglect.

PLEASE NOTE: This non-compliance was issued in relation to Complaint Inspection log #005152-18, which was completed concurrently with the Resident Quality Inspection log # 023251-18. [s. 19. (1)]

2. The licensee failed to ensure that all residents were protected from abuse by anyone.

A. Long Term Care Homes Act, 2007 defines Emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

i. During stage one of the RQI, resident #006 reported to the LTCH Inspector #561 that in June 2018, PSW #112 threatened the resident.

ii. The licensee's investigation notes indicated that the alleged PSW #112 admitted to threatening the resident using profane language.

iii. RPN #111 was interviewed by LTCH Inspector #561 and stated that resident #006 reported being mistreated by PSW #112. RPN #111 confirmed that the PSW admitted to the allegations and immediately reported this incident to the DOC. iv. The DOC acknowledged that PSW #112 emotionally abused resident #006.

The licensee failed to ensure that resident #006 was protected from abuse by the staff in the home.

B. Several CIS reports were submitted to the Director by the home related to resident #008 exhibiting responsive behaviours between coresidents #009, #011 and #012.
i. Clinical care records were reviewed and identified that resident #008 had a history of responsive behaviours towards residents. The resident had a plan of care in place to address these behaviours and interventions to prevent the behaviour from recurring. The home also had external resources implemented and BSO involvement in the assessment and development of strategies. -there were four incidents were resident #008 displayed responsive behaviours towards coresidents #009, #011 and #012.

ii. In an interview with the DOC and the ED they indicated that even though the home had interventions in place to prevent resident #008 from displaying behaviours towards coresidents, resident #008 continued to have altercations with coresidents.

The licensee failed to ensure that residents #009, #011 and #012 were protected from abuse by resident #008.

This area of non-compliance was identified during CIS Inspections, log

#00662317, #011415-17, #017748-17, #018372-17, and #01861917,

conducted concurrently during the RQI. [s. 19. (1)] ***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 O.Reg 79/10, s. 52. Pain management
Specifically failed to comply with the following:
s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2). Findings/Faits saillants :

1. The licensee failed to ensure that if the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose

A. The Ministry of Health and Long Term Care, received a complaint in March 2018, related to care concerns for resident #018. According to the complainant, the home failed to effectively treat the resident's pain.

i. Review of the medical records revealed that in 2018 resident #018 was admitted to the home. Review of the Minimum Data Set Home Care Assessment indicated in ‘Section Notes’ that resident had specific diagnosis. Due to deterioration in mobility and cognition, the resident was no longer able to manage their own activities of daily living. The MDS Home Care Assessment also identified that the resident required ongoing care, medical treatment of specified symptoms and assistance with daily activities. The admission physiotherapy assessment noted that the resident also had pain. ii. The home's policy 'Pain and Symptom Management:VII-G-30.10' directed registered staff to complete a pain assessment electronically on move in and readmission, for pain scores of two or more, when a resident reports or exhibits signs and symptoms of pain following implementation of pharmacological and non-pharmacological interventions and to consider initiating a pain study for 24 hours or longer to assist with the assessment of pain. In addition, staff were directed to monitor and evaluate the effectiveness of pain medications in relieving resident's pain using the pain scale in the vitals section of the electronic documentation.

iii. Review of the eMARS confirmed that the resident received routine administration of a non-steroidal anti-inflammatory, at which time, registered staff assessed the resident's pain and assigned a numerical value. During the resident's stay at the home, pain was documented; however, no electronic comprehensive pain assessment was completed. Interview with the ADOC confirmed that registered staff did not use the comprehensive pain assessment tool in PCC when resident #018 had a pain score of two or more on multiple occasions. (528) iv. Review of the progress notes, revealed documentation that the resident was described displaying signs of discomfort. Review of the plan of care did not include any comprehensive pain assessment or Pain Study Tool, as indicated in the 'Pain and Symptom Management' policy.

v. Interview with the ADOC confirmed that registered staff did not use the comprehensive pain assessment tool in PCC when resident #018 had a pain score of two or exhibited ongoing signs and symptoms of pain, as required in the 'Pain and Symptom Management' policy. (528)

vi. Review of the mandatory pain education, provided by the ADOC, for registered staff completed in 2017, included an Abby Pain Scale for measurement

of pain in people with dementia. Review of the medical record for resident #018 did not include any completed Abby Pain Scale assessments. Documentation under the 'vitals' section in PCC included numerical and Pain Assessment in Advanced Dementia (PAINAD) scales, however, interview with the DOC and ADOC confirmed that staff were to use the PAINAD when assessing a resident with cognitive impairment for pain. Pain Assessment in Advanced Dementia scale (PAINAD) was completed approximately 33 percent (%) of the time. The Admission MDS Assessment, confirmed that the resident had cognitive impairment. Interview with the DOC confirmed that staff used the PAINAD to assess resident's pain only approximately a third of the time. vii. Review of the progress notes documentation indicated the resident was awaiting a medication review by the Nurse Practitioner(NP) for pain concerns; however, the plan of care did not include a review of the resident's medications related to pain. Interview with the NP confirmed that the home attempted to reach the resident's physician before making any decisions related to the plan of care.

B. The plan of care for resident #020 identified that the resident had acute pain and interventions included but were not limited to, routine administration of a non steroidal anti-inflammatory.
a. Review of the electronic Medication Administration Records (eMARS) from July to September 2018, revealed that staff assessed the resident's pain when administering the medication and pain score of two or more was noted approximately 32 times.

i. Review of resident #020's plan of care did not include any completed comprehensive pain assessments, as outlined in the 'Pain and Symptoms Management' policy.

ii. Interview with the ADOC and DOC clarified that according to the home's policy, when the resident's pain score was two or more, registered staff were to complete the comprehensive 'pain assessment' under the 'assessments tab' in Point Click Care (PCC). Interview with the ADOC confirmed that a comprehensive pain assessment for resident #020 was not completed from July to September, 2018, as required. (528)

This non-compliance was issued as a result of Complaint Inspection log # 005152 -18, which was completed concurrently with the Resident Quality Inspection log #023251-18 [s. 52. (2)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A3)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Findings/Faits saillants :

(A4)
1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice weekly by the method of her or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The Ministry of Health and Long Term Care, received an anonymous complaint in August 2018, related to staffing concerns. According to the complainant, residents were missing their scheduled baths.

A. In order to identify if any residents had expressed concerns related to staffing, Resident Council Minutes for August and September 2018, were reviewed and

revealed that residents had expressed concerns that they were missing their baths due to insufficient staffing on the weekends.

B. Review of the plan of care for resident #037 identified that the resident required assistance with activities of daily living (ADLs).
i. The Point of Care Documentation Survey Report revealed for bathing that the "activity did not occur" on six occasions over a three month period. ii. A list of PSW staff shortages was provided to the LTC Homes Inspector #528 in September 2018, by the Unit Scheduling Coordinator, confirmed that the PSW staff in the home worked short at least one PSW on the evenings that the staff documented resident #037's bath "did not occur" from the identified time period. iii. In a follow up interview with resident #037 in September 2018, they indicated that they often missed their weekend bath because the home was short staffed and it was not always made up.

C. Review of the plan of care for resident #038, identified that the resident required the assistance staff with ADLs
i. The Point of Care Documentation Survey Report identified for bathing that the "activity did not occur" on five occasions over a three month period. ii. Interview with the Unit Scheduling Clerk confirmed that the PSW staff worked short at least one PSW on the evenings that the staff documented resident #038's bath "did not occur" from the identified time period.

D. Review of the plan of care for resident #009 identified that the resident required assistance with ADLs.
i. The Point of Care Documentation Survey Report from related to bathing, revealed that the "activity did not occur", on seven occasions over a three month period. ii. Interview with the Unit Scheduling Coordinator, confirmed that the PSW staff worked short at least one PSW in the home on on the days that the staff documented resident #009's bath "did not occur" during the identified time period.

E. Review of Point of Care and the progress notes did not include any documentation that when the bathing did not occur for residents #037, #038 and #009, that it was made up at a different time.

F. Interview with PSW #138, #139, #140, #141 and #142 all confirmed that they worked short on a regular basis and when they were not working at their full compliment, baths were often missed. Interviews with PSW #138, #139 and #142 all confirmed that when a resident's bath was missed they would document in Point of Care that the "activity did not occur". In the interview PSW #142 reported that they did not have sufficient staff to ensure that if baths were missed, they would be rescheduled. (528)

PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection log #005152-18, which was completed concurrently with the Resident

Quality Inspection log #023251-18. [s. 33.] ***Additional Required Actions:***

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended: CO# 005

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services
Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidencebased practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The Ministry of Health and Long Term Care, received an anonymous complaint in August 2018, related to care staffing shortages. According to the complainant, residents were missing their scheduled baths due to ongoing staffing shortages.

A. In order to identify if residents had raised issues related to staffing, the Resident Council Minutes in August and September 2018, were reviewed. It was identified that residents had expressed concerns at the meetings that they were missing their baths due to insufficient staffing. A follow up interview with resident #037 confirmed that they continued to miss their scheduled bath on the weekends, due to short staffing.
B. Reviewed bathing records over a three month period which revealed the following:

i. Resident #037 did not receive a scheduled bath on six occasions
ii. Resident #038 did not receive a scheduled bath on five occasions. iii Resident #009 did not receive a scheduled bath on seven occasions.

C. A list of PSW staff shortages provided to the LTC Homes Inspector #528 in September 2018, by the Unit Scheduling Coordinator, confirmed that the PSW staff worked short at least one PSW in the home on the days a bath was not documented as identified for residents #037 #038 and #009.

D. Interviews with PSW #138, #139, #140, #141 and #142 confirmed that they worked short on a regular basis and when they were not working at their full compliment, baths were often missed. Interviews with PSW #138, #139 and #142 confirmed that when a resident's bath was missed, and if they had time to document, they would document in Point of Care (POC) that the "activity did not occur". In an interview with PSW #142 they reported that they did not have sufficient staff to ensure that if baths were missed, they would be rescheduled.

E. Review of Fox Ridge Care Community Staffing Compliment, provided by the DOC, outlined the compliment for five home areas, totaling 123 beds and required 16 PSW staff on day shift, 12 PSW staff on evening shift, and six PSW staff on night shift.

F. Review of the list of staff shortages, provided by the Unit Scheduling Clerk September 2018, identified the following pattern of PSW staff working less their full complement:

i. In July 2018, day shift, PSW staff worked short at least one staff member 65 percent (%) of the time. ii. In July 2018, evening shift, PSW staff worked short at least one staff member 45 % of the time. iii. In July 2018, night shift staff members worked short one PSW 16 % of the time. iv. In August 2018, day shif PSW staff worked short at least one PSW 77% of the time.
v. In August 2018, evening PSW staff worked short at least one PSW 77% of the time. vi. In August 2018, night staff PSW staff worked short at least one

PSW 23% of the time. vii. From September 1 to 26, 2018, day shift PSW staff worked short at least one PSW 46% of the time. viii. From Sept 1 to 26, 2018, evening shift PSW staff worked short at least one PSW 61% of the time.

ix. From September 1 to 26, 2018, the PSW night staff worked short at least one PSW 29% of the time.

G. Reviewed of list of PSW staffing shortages, which identified that on specified dates in July August and September 2018, housekeeping staff were called in to "help". Interview with housekeeping staff #145 and #146 confirmed that they had been called into help PSW staff when they worked short. They reported that they were responsible for transporting residents, bringing residents their meals, serving drinks to residents they knew, and transferring resident's; all under PSW direction. In the interview with housekeeping staff #145 and #146, they confirmed they had received Safe Lift and Transferring education but did not have their Personal Worker Certificate.

H. Review of the List of RN shortages from July to September 2018, identified that the home operated without an RN in the building approximately 28 times on evening shift and 27 times on night shift, as confirmed by the Unit Scheduling Clerk.

I. Interview with PSW #141 and RPN #149 identified that when they were working short staffed they were unable to respond to activated devices in a timely manner for resident #041. Review of the plan of care for resident #041 revealed that they had a history of falling and were at risk for falls. It was also noted in the document the home referred to as the care plan, that the resident required a device prevent falls. Review of the staffing shortages list provided by the Unit Scheduling Clerk, confirmed that staff worked one PSW short on an identified evening in August 2018, when the resident fell. Interview with RPN #149 confirmed that the device had activated and they were unable to respond in a timely manner.

J. Interview with the ED and DOC, identified that the home had updated the staffing plan to include but was not limited to, hired a registered nurse, changed registered nurse schedules to accommodate shortages, consulted with the Ontario

Nurses Association related to attendance management, the DOC described a new plan for bathing to ensure residents' bathing needs were met, and continuous ongoing recruitment and job fairs. (528)

PLEASE NOTE: This non-compliance was issued as a result of Complaint Log # 005152-18, which was completed concurrently with the Resident Quality Inspection log #023251-18. [s. 31. (3)]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan

Specifically failed to comply with the following:

s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
7. Skin condition, including interventions. O. Reg. 79/10, s. 24 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the 24-hour admission care plan must have identified the resident and must have included, at a minimum, the following with respect to the resident: skin condition, including interventions.

The Ministry of Health and Long Term Care, received a complaint in March 2018, related to skin and wound care. According to the complainant, the home failed to assess resident leading to an area of altered skin integrity.

Review of medical records for resident #018 revealed that they were admitted to the home with areas of altered skin integrity. In addition, the MDS Home Care Assessment identified that the resident had areas of altered skin integrity requiring ongoing care. Review of the plan of care did not include any interventions related to the resident's skin conditions. Interview with the Wound Care Lead #148, confirmed that the home did not establish interventions for resident #009's altered skin integrity on admission. (528)

PLEASE NOTE: This non-compliance was issued in relation to Complaint Inspection log #005152-18, which was completed concurrently with Resident Quality Inspection (RQI) log # 023251-18. [s. 24. (2) 7.]

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 24-hour admission care plan must identify the resident and must include, at a minimum, the following with respect to the resident: skin condition, including interventions, to be implemented voluntarily.

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

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
18. Special treatments and interventions. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care was based on, at a minimum, interdisciplinary assessment of special treatments and interventions.

The Ministry of Health and Long Term Care, received a complaint in March 2018, related to neglect of a resident, including but not limited to, that the home failed to provide the resident with palliative care.

i. Review of the medical records revealed that in 2018, a specified resident was admitted to the home. Review of the Minimum Data Set Home Care Assessment indicated in 'Section Notes' that resident had specific diagnosis. Due to deterioration in mobility and cognition, the resident was no longer able to manage their own activities of daily living. The MDS Home Care Assessment also identified that the resident required ongoing care, medical treatment of specific symptoms and assistance with daily activities. ii. The homes policy 'Palliative Care Overview VII-G-30.30a', dated January 2015, outlined the palliative approach as follows: when the resident's condition was not amenable to cure and the symptoms of the disease required effective symptom management, a palliative approach would have been appropriate. The primary goal was to improve the resident's level of comfort and function, a combination of active treatment to manage symptoms while continuing with the palliative approach was considered best practice. Interview with the DOC identified that the specified resident met the requirements for palliative care. Interview with the Nurse Practitioner revealed that, on an unidentified day, the family of the resident notified them that the resident was terminal. iii. The policy 'Palliative Care – Care of the Resident, VII-G-30.30', revised January 2015, directed registered staff to assess all residents for a decline in condition using tools including but not limited to: RAI MDS Outcome Scores (CHESS), Palliative Performance Scale, pain assessments, residents medication condition has been identified as terminal or shortened life expectancy, conduct an interdisciplinary care conference with the resident and POA to discuss changes in residents condition and advance care planning, and establish a plan of care to meet resident's needs. Complete required assessments triggered based on changes in residents status ie pain,

skin, continence. iv. Review of the plan of care for the specified resident identified that the CHESS score from Admission MDS Assessment and RAPS for the specified resident was inconsistent with the MDS Home Care Assessment and direct care and registered
staff assessments of the resident's condition. Furthermore, a Palliative Performance Scale was not completed, as confirmed in an interview with the DOC.

v. In addition, review of the plan of care did not include, 'required assessments' described in the 'Palliative Care' policy for pain and skin. Interviews with the ADOC and Wound Care Lead confirmed that the home failed to assess skin and pain as required in the programs.

As a result of inconsistent admission assessments, the absence of comprehensive pain assessments or interventions and skin and wound assessment and treatment plans, the resident's plan of care was not based on an interdisciplinary assessment of special treatments and interventions, related to Palliative Care, as outlined in the home's Palliative Care policy. (528)

PLEASE NOTE: This non-compliance was issued in relation to Complaint Inspection log #005152-18, which was completed concurrently with the Resident

Quality Inspection log # 023251-18. [s. 26. (3) 18.] ***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 resident's plan of care is based on, at a

minimum, interdisciplinary assessment of special treatments and interventions, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of

the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).

3. A response shall be made to the person who made the complaint, indicating,

i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. 2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief
The Ministry of Health and Long Term Care, received a complaint in March 2018, related to neglect of a resident. According to the complainant, in a follow-up call during the course of the inspection, they felt that the home did not address their ongoing care concerns.

i. The home's 'Complaint Management Program: XXIII-A-10.40', last revised October 2017, directed the following but not limited to, the Executive Director or designate to contact or arrange to meet the complainant to obtain information about the area(s) of concern, conduct and document an internal investigation utilizing the Complaint Record Form, contact complainant and communicate actions taken to resolve the complaint and update complaint and update the Complaint Record Form. ii. Review of the medical record for resident #018, which included two progress notes on an identified day in February 2018, which documented that the family had concerns related to care of the resident. Review of the 2018 Complaints Log, did not include any further details regarding the concerns. iii. Interview with the DOC confirmed that the concerns documented in PCC by registered staff, from the identified day, were not communicated to them, as required for follow-up; and therefore, the complaint was not addressed in accordance with the home's 'Complaint Management Program'. (528)
This non-compliance was issued as a result of Complaint Inspection #005152-18, which was completed concurrently with the Resident Quality Inspection log #023251-18. [s. 101. (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 to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
3. A response shall be made to the person who made the complaint, indicating, i. what the licensee has done to resolve the complaint, or ii. that the licensee believes the complaint to be unfounded and the reasons for the belief, to be implemented voluntarily.

Issued on this 27th day of June, 2019 (A4)

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

Original report signed by the inspector.

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) Amended by CYNTHIA DITOMASSO (528) - (A4)

Inspection No./ No de l'inspection 2018_570528_0002 (A4)

Appeal/Dir# / Appel/Dir#:

Log No. / No 005152-18 (A4)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport: Jun 27, 2019(A4)

Licensee / Titulaire de permis : 2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8

LTC Home / : Fox Ridge Care Community
389 West Street, BRANTFORD, ON, N3R-3V9

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Sandy Croley

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To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
i. within 24 hours of the resident's admission, ii. upon any return of the resident from hospital, and
iii. upon any return of the resident from an absence of greater than 24 hours;

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

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's

condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

(A4)
The licensee must be compliant with s. 50(2)(b)(i)(ii) and (iv) of Ontario Regulation 79/10.
Specifically the licensee must:

a) Ensure all residents with a new or existing area of altered skin integrity:
i. receive a skin and wound assessment by a member of the registered nursing staff, using a clinically appropriate assessment tool,
ii. receive immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection, and iii. are reassessed at least weekly by a member of the registered nursing staff.

b) Complete plan of care audits of those residents who are at risk or have actual altered skin integrity, at an interval of the home's choice, to ensure that the assessment, treatment, and reassessments are completed as outlined in the home's Skin and Wound Care Program.

c) Keep a documented record of audits completed.

Grounds / Motifs :

(A3)
1. The licensee failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The Ministry of Health and Long Term Care, received a complaint in March 2018, related to skin and wound care. According to the complainant, the home failed to assess the resident leading to an area of altered skin integrity.
i. Review of the plan of care revealed that in 2018, resident #018 was admitted to the home with altered skin integrity. Several days after admission, the Point of Care (POC) record identified that the resident had new altered skin integrity. A progress note also revealed that the family of the resident notified registered staff of the areas .
ii. Review of the plan of care did not include a skin assessment, by a member of the registered nursing staff using a clinically appropriate assessment instrument, until eleven days after the new area of altered skin integrity was initially documented. At which time, the altered skin integrity had changed. iii. Interview with the Director of Care, confirmed that registered staff did not complete an assessment at the time the altered skin integrity was identified. (528) PLEASE NOTE: This area of non-compliance was identified during a Complaint

Inspection, log #005152-18, which was conducted concurrently during the Resident Quality Inspection (RQI) log #023251-18. [s. 50. (2) (b) (i)]

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

The Ministry of Health and Long Term Care, received a complaint in March 2018, related to related skin and wound care. According to the complainant, the home failed to assess resident resulting in altered skin integrity.

i. Review of the plan of care for resident #018 identified that in 2018 the resident

had altered skin integrity. Review of the treatment administration record (TAR), did not include immediate treatment and interventions to promote healing, until several days after the the altered skin integrity was identified.
b. Interview with the Director of Care, confirmed that resident #018 did not

receive immediate skin and wound care treatment, as required in the home's Skin and Wound Care Program. (528)
ii. Resident #018 was admitted to the home with altered skin integrity. On the skin and wound admission assessment and in admission progress notes, registered staff documented altered skin integrity.
d. Review of the the electronic Treatment Administration Record (eTAR) did not include any treatment orders to one of the areas until 21 days after admission, when
the family brought concerns forward related to infection
e. Review of the electronic Treatment Administration Record did not include any treatment plan for another area of altered skin inteigrty.
f. Interview with the Wound Care Lead #148, confirmed that the eTARS for resident #018 did not include immediate treatment and interventions to reduce pain, promote healing and prevent infection for areas of altered skin integrity.
(528)

PLEASE NOTE: This area of non-compliance was identified during a Complaint Inspection, log #005152-18, which was conducted concurrently during the Resident Quality Inspection (RQI) log #023251-18. [s. 50. (2) (b) (ii)]

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

The Ministry of Health and Long Term Care, received a complaint in June 2017, related to skin and wound care. According to the complainant, the resident had altered skin integirty.

iii. Review of the plan of care for resident #020, identified that they had recurrent areas of altered skin integrity and directed staff to monitor for signs and symptoms of infection.
iv. In May 2017, the skin and wound assessment identified a new area of altered skin integrity. Review of the plan of care did not include weekly assessments for one week, at which time, family brought concerns forward of infection.
v. Interview with the ADOC confirmed that the registered staff did not complete a weekly assessment of resident #020's altered skin integrity for one week until the family brought forward concerns related to infection. (528)

PLEASE NOTE: This non-compliance was issued related to Complaint Inspection log # 011543-17, completed concurrently with Resident Quality Inspection log #023251-18. [s. 50. (2) (b) (iv)]

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2019(A3)

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. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be compliant with s.8 (3) of the LTCHA.

Specifically the licensee must ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

(A2)

1. The licensee failed to ensure that there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present at all times unless there was an allowable exception to this requirement (see definition/description for list of exceptions as stated in section 45.(1) and 45.1 of the regulation).

The Ministry of Health and Long Term Care, received a complaint in March 2018, related to care concerns for a resident. In a follow up call with the complainant,

during the course of the inspection, they identified concerns that home worked short staffed and they felt it contributed to neglect of the resident.

A. The LTC Homes Inspector #528 requested a list of shortages from the home. A list provided by the Unit Scheduling Clerk, outlining RN shortages from July to September 2018, was reviewed and revealed that the home operated without a registered nurse in the building approximately 28 times on evening shift and 27 times on night shift over the three month period.
i. Interview with the Unit Scheduling Clerk, confirmed that the home worked without a registered nurse in the building as outlined on the RN Shortages List and also revealed that the home had two staff members off over the last few months; and therefore, were unable to fill absences in the schedule. They also confirmed that if an RN could not be replaced an RPN was called in for the shift. ii. Interview with the ED and DOC confirmed that they had one staff member return and have hired a part time RN to meet legislative requirements, but acknowledged that recruitment and retention was an ongoing concern and challenge. (528)

PLEASE NOTE: This non-compliance was issued as a result of complaint inspection #005152-18, which was completed concurrently with the Resident Quality Inspection log #023151-18.
B. he severity of this issue was determined to be a level 2 as there was potential for actual risk to the residents. The scope of the issue was patterned 2 as it was a recurring occurrence in the home. The home had a level 3 history of on-going noncompliance with this section of the Act that included a previous written notification
(WN) issued in June 2017 (2017_556168_0022). (528)

This order must be complied with by / Mar 04, 2019(A1)

Vous devez vous conformer à cet ordre d'ici le :

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

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

Order / Ordre :

(A1)
The licensee must be compliant with s.19 (1) of the LTCHA. The licensee shall

prepare, submit and implement a plan to ensure:

i. all residents who require palliative care, skin and wound care, and pain management are not neglected by the licensee or staff.

The plan must include, but is not limited, to the following:
a. a description of an ongoing auditing process to ensure that any resident requiring care related to palliative care, skin and wound care, and pain management received appropriate assessments and interventions.
b. who will be responsible for the audits and evaluating the results c. how the audits will be documented ii. resident #006,

#009 and #012 are protected from abuse.

Grounds / Motifs :
(A1)

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

A. The Ministry of Health and Long Term Care, received a complaint in March 2018, related to care concerns for a resident in the home. According to the complainant, the home neglected to manage the resident's pain or care for the resident's areas of skin breakdown.

For the purposes of the Long-Terms Care Homes Act, 2007 and Ontario Regulation 79/10, 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 and well-being of one or more residents.

i. Review of the medical records revealed that in 2018 resident #018 was admitted to the home. Review of the Minimum Data Set Home Care Assessment indicated in 'Section Notes' that resident had specific diagnosis. Due to deterioration in mobility and cognition, the resident was no longer able to manage their own activities of daily living. The MDS Home Care Assessment also identified that the resident required care to altered skin integrity, medical treatment of specified symptoms and assistance with daily activities. ii. The plan of care was reviewed and identified the following inaction:

a. The MDS Home Care Assessment and admission skin and wound care assessment, identified that the resident was admitted to the home with an area of altered skin integrity requiring care. Interview with the Wound Care Lead #148 confirmed that a treatment plan was not established for the area until family had concerns of infection, three weeks later.

b. Review of an admission progress note identified that the resident had an additionalarea of altered skin integrity. Nine days later, registered staff documented that they were applying treatment but, interview with the Wound Care Lead #148 confirmed, that the plan of care did not include a treatment plan until several days later.

c. Several days after admission, Point of Care documentation, revealed the resident had a new area of altered skin integrity; however, an initial skin and wound assessment, using a clinically appropriate tool, was not completed for several days.

At which time, the area was documented as showing signs of infection.

d. Although the resident's plan of care included documented pain on the eMARS and the resident was described as showing symptoms of pain or discomfort in the

progress notes, a comprehensive pain assessment was not completed in Point Click Care, as required by the home's 'Pain and Symptom Management' policy, confirmed in an interview with the ADOC. Furthermore, additional pharmacological pain interventions were not implemented until two days before the resident was discharged.

d. Review of the progress notes confirmed that registered staff documented that the family of resident #018 had ongoing care concerns of the resident. The home did not investigate these concerns according to their Reporting and Complaints Procedure, as confirmed with an interview with the DOC.

e. Review of physician order history confirmed that the resident the plan of care did not reflect pre-admission diagnosis.

f. The home's policy "Palliative Care - Care of the Resident", revised January 2015, identified that all palliative residents should have comprehensive assessments and a current, up to date, plan of care. The procedure included directions included coordination of an interdisciplinary care conference to discuss changes in residents condition and advanced care planning. A care conference was held a day before the family had requested the resident be transferred. Interview with the RAI-MDS Coordinator confirmed that the care conference was held days before the resident had left the facility. iii. As a result of the pattern of inaction related to the failure to complete comprehensive pain assessments, skin and wound assessment, and treatment plans, resident #018's health and well-being was jeopordized and they were not protected from neglect.

PLEASE NOTE: This non-compliance was issued in relation to Complaint Inspection log #005152-18, which was completed concurrently with the Resident Quality Inspection log # 023251-18. [s. 19. (1)]
2. The licensee failed to ensure that all residents were protected from abuse by anyone.

A. Long Term Care Homes Act, 2007 defines Emotional abuse as any threatening, insulting, intimidating or humiliating gestures, actions, behaviour or remarks, including imposed social isolation, shunning, ignoring, lack of acknowledgement or infantilization that are performed by anyone other than a resident.

i. During stage one of the RQI, resident #006 reported to the LTCH Inspector #561 that in June 2018, PSW #112 threatened the resident.

ii. The licensee's investigation notes indicated that the alleged PSW #112 admitted to threatening the resident using profane language.

iii. RPN #111 was interviewed by LTCH Inspector #561 and stated that resident

#006 reported being mistreated by PSW #112. RPN #111 confirmed that the PSW admitted to the allegations and immediately reported this incident to the DOC.

iv. The DOC acknowledged that PSW #112 emotionally abused resident #006 and was disciplined.

The licensee failed to ensure that resident #006 was protected from abuse by the staff in the home.

B Several CIS reports were submitted to the Director by the home related to resident #008 exhibiting responsive behaviours between coresidents #009, #011 and #012.

ii. Clinical care records were reviewed and identified that resident #008 had a

history of responsive behaviours towards residents. The resident had a plan of care in place to address these behaviours and interventions to prevent the behaviour from recurring. The home also had external resources implemented and BSO involvement in the assessment and development of strategies.
-there were four incidents were resident #008 displayed responsive behaviours towards coresidents #009, #011 and #012.

iii. In an interview with the DOC and the ED they indicated that even though the home had interventions in place to prevent resident #008 from displaying behaviours towards coresidents, resident #008 continued to have altercations with coresidents.

The licensee failed to ensure that residents #009, #011 and #012 were protected from abuse by resident #008.

This area of non-compliance was identified during CIS Inspections, log #006623-17, #011415-17, #017748-17, #018372-17, and #018619-17, conducted concurrently during the RQI.

C. The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was isolated 1 as it was one out of three residents in the home. The home had a level 3 history of on-going non-compliance with this section of the Act that included a previous voluntary plan of correction (VPC) issued in April 2017 (2017_556168_0010). (528)

This order must be complied with by / Mar 04, 2019

Vous devez vous conformer à cet ordre d'ici le :

Order # / Ordre no : 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

(A3)
The licensee must be compliant with s.52 (2) of Ontario Regulation 79/10.

Specifically the licensee must ensure that when a resident's pain, including but not limited to, resident #020, is not relieved by initial interventions, the resident(s) is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

In addition, the home shall review and revise the the Pain and Symptom Management Policy to include clear directions to staff in relation to which pain assessment tools are to be used by staff when residents are experiencing pain and these changes are to be documented.

Lastly, the home shall conduct audits, at the schedule of their choosing, to ensure that registered staff are assessing and treating resident's pain as outlined in the Pain and Symptom Management Policy.

Grounds / Motifs :

1. 1. The licensee failed to ensure that if the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose

A. The Ministry of Health and Long Term Care, received a complaint in March 2018, related to care concerns for resident #018. According to the complainant, the home failed to effectively treat the resident's pain.

i. Review of the medical records revealed that in 2018 resident #018 was admitted to the home. Review of the Minimum Data Set Home Care Assessment indicated in 'Section Notes' that resident had specific diagnosis. Due to deterioration in mobility and cognition, the resident was no longer able to manage their own activities of daily living. The MDS Home Care Assessment also identified that the resident required ongoing care, medical treatment of specified symptoms and assistance with daily activities. The admission physiotherapy assessment noted that the resident also had pain.

ii. The home's policy 'Pain and Symptom Management:VII-G-30.10' directed registered staff to complete a pain assessment electronically on move in and readmission, for pain scores of two or more, when a resident reports or exhibits signs and symptoms of pain following implementation of pharmacological and nonpharmacological interventions and to consider initiating a pain study for 24 hours or longer to assist with the assessment of pain. In addition, staff were directed to monitor and evaluate the effectiveness of pain medications in relieving resident's pain using the pain scale in the vitals section of the electronic documentation. iii. Review of the eMARS confirmed that the resident received routine administration of a non-steroidal anti-inflammatory, at which time, registered staff assessed the resident's pain and assigned a numerical value. During the resident's stay at the home, pain was documented; however, no electronic comprehensive pain assessment was completed. Interview with the ADOC confirmed that registered staff did not use the comprehensive pain assessment tool in PCC when resident #018 had a pain score of two or more on multiple occasions. (528)

iv. Review of the progress notes, revealed documentation that the resident was described displaying signs of discomfort. Review of the plan of care did not include any comprehensive pain assessment or Pain Study Tool, as indicated in the 'Pain and Symptom Management' policy.
v. Interview with the ADOC confirmed that registered staff did not use the comprehensive pain assessment tool in PCC when resident #018 had a pain score of two or exhibited ongoing signs and symptoms of pain, as required in the 'Pain and Symptom Management' policy. (528) vi. Review of the mandatory pain education,

provided by the ADOC, for registered staff completed in 2017, included an Abby Pain Scale for measurement of pain in people with dementia. Review of the medical record for resident #018 did not include any completed Abby Pain Scale assessments. Documentation under the 'vitals' section in PCC included numerical and Pain Assessment in Advanced Dementia (PAINAD) scales, however, interview with the DOC and ADOC confirmed that staff were to use the PAINAD when assessing a resident with cognitive impairment for pain. Pain Assessment in Advanced Dementia scale (PAINAD) was completed approximately 33 percent (%) of the time. The Admission MDS Assessment, confirmed that the resident had cognitive impairment. Interview with the DOC confirmed that staff used the PAINAD to assess resident's pain only approximately a third of the time. vii. Review of the progress notes documentation indicated the resident was awaiting a medication review by the Nurse Practitioner(NP) for pain concerns; however, the plan of care did not include a review of the resident's medications related to pain. Interview with the NP confirmed that the home attempted to reach the resident's physician before making any decisions related to the plan of care.

B. The plan of care for resident #020 identified that the resident had acute pain and interventions included but were not limited to, routine administration of a non steroidal anti-inflammatory.
a. Review of the electronic Medication Administration Records (eMARS) from July to September 2018, revealed that staff assessed the resident's pain when

administering the medication and pain score of two or more was noted approximately 32 times. i. Review of resident #020's plan of care did not include any completed comprehensive pain assessments, as outlined in the 'Pain and Symptoms Management' policy.
ii. Interview with the ADOC and DOC clarified that according to the home's policy, when the resident's pain score was two or more, registered staff were to complete the comprehensive 'pain assessment' under the 'assessments tab' in Point Click Care (PCC). Interview with the ADOC confirmed that a comprehensive pain assessment for resident #020 was not completed from July to September, 2018, as required. (528)

This non-compliance was issued as a result of Complaint Inspection log # 00515218, which was completed concurrently with the Resident Quality Inspection log #02325118

C. The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was patterned 2 as it included two out of three residents in the home. The home had a level 2 history of on-going unrelated non-compliance. (528) (528)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jun 17, 2019(A3)

Order # / Ordre no : 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. Bathing

Order / Ordre :

The licensee must be compliant with s. 33 of Ontario Regulation 79/10.

Specifically the licensee must:

i. Ensure all residents, including residents #037, #038, and #009 are bathed twice a week, according to their preference.
ii. Develop a written contingency plan for every shift to outline how staff are to ensure baths are made up either through the day or later in the week and post the plan in each home area.

iii. Complete an audit of scheduled baths, at an interval of the home's choice, to monitor whether the task is being completed. iv. Keep a documented record of audits completed.

Grounds / Motifs :

(A4)
1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice weekly by the method of her or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The Ministry of Health and Long Term Care, received an anonymous complaint in August 2018, related to staffing concerns. According to the complainant, residents were missing their scheduled baths.

A. In order to identify if any residents had expressed concerns related to staffing, Resident Council Minutes for August and September 2018, were reviewed and revealed that residents had expressed concerns that they were missing their baths due to insufficient staffing on the weekends.

B. Review of the plan of care for resident #037 identified that the resident required assistance with activities of daily living (ADLs).
i. The Point of Care Documentation Survey Report revealed for bathing that the "activity did not occur" on six occasions over a three month period. ii. A list of PSW staff shortages was provided to the LTC Homes Inspector #528 in September 2018, by the Unit Scheduling Coordinator, confirmed that the PSW staff in the home worked short at least one PSW on the evenings that the staff documented resident #037's bath "did not occur" from the identified time period. iii. In a follow up interview with resident #037 in September 2018, they indicated that they often missed their weekend bath because the home was short staffed and it was not always made up.

C. Review of the plan of care for resident #038, identified that the resident required the assistance staff with ADLs
i. The Point of Care Documentation Survey Report identified for bathing that the "activity did not occur" on five occasions over a three month period. ii. Interview with the Unit Scheduling Clerk confirmed that the PSW staff worked short at least one PSW on the evenings that the staff documented resident #038's bath "did not occur" from the identified time period.

D. Review of the plan of care for resident #009 identified that the resident required assistance with ADLs.
i. The Point of Care Documentation Survey Report from related to bathing, revealed that the "activity did not occur", on seven occasions over a three month period. ii. Interview with the Unit Scheduling Coordinator, confirmed that the PSW staff worked short at least one PSW in the home on on the days that the staff documented resident #009's bath "did not occur" during the identified time period.

E. Review of Point of Care and the progress notes did not include any documentationthat when the bathing did not occur for residents #037, #038 and #009, that it was made up at a different time.

F. Interview with PSW #138, #139, #140, #141 and #142 all confirmed that they worked short on a regular basis and when they were not working at their full compliment, baths were often missed. Interviews with PSW #138, #139 and #142 all confirmed that when a resident's bath was missed they would document in Point of Care that the "activity did not occur". In the interview PSW #142 reported that they did not have sufficient staff to ensure that if baths were missed, they would be rescheduled. (528)

PLEASE NOTE: This non-compliance was issued as a result of Complaint Inspection log #005152-18, which was completed concurrently with the Resident Quality Inspection log #023251-18. [s. 33.]

G. The severity of this issue was determined to be a level 1 as there was minimal harm to the resident. The scope of the issue was widespread 3 as it included three out of three residents in the home. The home had a level 3 history of on-going noncompliance with a voluntary plan of correction (VPC) issued in March 2017 (2017_556168_0010). (528)

This order must be complied with by /

Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2019

Order # /
Ordre no : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and

(e) be evaluated and updated at least annually in accordance with evidencebased practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be compliant with s. 31(3) of Ontario Regulation 79/10.

The licensee shall prepare, submit and implement a plan to ensure the plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.

The plan must include, but is not limited, to the following:

a. steps that will be taken to ensure that the home is staffed at the assessed staffing complement needs for personal support workers and registered nurses
b. how the home will ensure the residents' are bathed at a minimum of two days a week
c. how the home will ensure that they meet the requirement of the Act for 24-hour nursing care
d. recruitment and retention of staff

Please submit the written plan, quoting log number #2018_570528_0002 and inspector Cynthia Di Tomasso by email to HamiltonSAO.moh@ontario.ca by December 20, 2018.
Please ensure that the submitted written plan does not contain any PI/PHI. Check with your SAO regarding the delivery email address.

Grounds / Motifs :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The Ministry of Health and Long Term Care, received an anonymous complaint in August 2018, related to care staffing shortages. According to the complainant, residents were missing their scheduled baths due to ongoing staffing shortages.

A. In order to identify if residents had raised issues related to staffing, the Resident Council Minutes in August and September 2018, were reviewed. It was identified that residents had expressed concerns at the meetings that they were missing their baths due to insufficient staffing. A follow up interview with resident #037 confirmed that they continued to miss their scheduled bath on the weekends, due to short staffing.

B. Reviewed bathing records over a three month period which revealed the following:
i. Resident #037 did not receive a scheduled bath on six occasions ii.
Resident #038 did not receive a scheduled bath on five occasions. iii
Resident #009 did not receive a scheduled bath on seven occasions.

C. A list of PSW staff shortages provided to the LTC Homes Inspector #528 in September 2018, by the Unit Scheduling Coordinator, confirmed that the PSW staff worked short at least one PSW in the home on the days a bath was not documented as identified for residents #037 #038 and #009.

D. Interviews with PSW #138, #139, #140, #141 and #142 confirmed that they worked short on a regular basis and when they were not working at their full compliment, baths were often missed. Interviews with PSW #138, #139 and #142 confirmed that when a resident’s bath was missed, and if they had time to document, they would document in Point of Care (POC) that the “activity did not occur”. In an interview with PSW #142 they reported that they did not have sufficient staff to ensure that if baths were missed, they would be rescheduled.

E. Review of Fox Ridge Care Community Staffing Compliment, provided by the DOC, outlined the compliment for five home areas, totaling 123 beds and required 16 PSW staff on day shift, 12 PSW staff on evening shift, and six PSW staff on night shift.

F. Review of the list of staff shortages, provided by the Unit Scheduling Clerk

September 2018, identified the following pattern of PSW staff working less their full complement:
i. In July 2018, day shift, PSW staff worked short at least one staff member 65 percent (%) of the time. ii. In July 2018, evening shift, PSW staff worked short at least one staff member 45 % of the time. iii. In July 2018, night shift staff members worked short one PSW 16 % of the time. iv. In August 2018, day shif PSW staff worked short at least one PSW 77% of the time.
v. In August 2018, evening PSW staff worked short at least one PSW 77% of the time. vi. In August 2018, night staff PSW staff worked short at least one PSW 23% of the
time.

vii. From September 1 to 26, 2018, day shift PSW staff worked short at least one PSW 46% of the time.
viii. From Sept 1 to 26, 2018, evening shift PSW staff worked short at least one PSW 61% of the time. ix. From September 1 to 26, 2018, the PSW night staff worked short at least one PSW 29% of the time.

G. Reviewed of list of PSW staffing shortages, which identified that on specified dates in July August and September 2018, housekeeping staff were called in to "help". Interview with housekeeping staff #145 and #146 confirmed that they had been called into help PSW staff when they worked short. They reported that they were responsible for transporting residents, bringing residents their meals, serving drinks to residents they knew, and transferring resident's; all under PSW direction. In the interview with housekeeping staff #145 and #146, they confirmed they had

received Safe Lift and Transferring education but did not have their Personal Worker Certificate.

H. Review of the List of RN shortages from July to September 2018, identified that the home operated without an RN in the building approximately 28 times on evening shift and 27 times on night shift, as confirmed by the Unit Scheduling Clerk.

I. Interview with PSW #141 and RPN #149 identified that when they were working short staffed they were unable to respond to activated devices in a timely manner for resident #041. Review of the plan of care for resident #041 revealed that they had a history of falling and were at risk for falls. It was also noted in the document the

home referred to as the care plan, that the resident required a device prevent falls. Review of the staffing shortages list provided by the Unit Scheduling Clerk, confirmed that staff worked one PSW short on an identified evening in August 2018, when the resident fell. Interview with RPN #149 confirmed that the device had activated and they were unable to respond in a timely manner.

J. Interview with the ED and DOC, identified that the home had updated the staffing plan to include but was not limited to, hired a registered nurse, changed registered nurse schedules to accommodate shortages, consulted with the Ontario Nurses Association related to attendance management, the DOC described a new plan for bathing to ensure residents' bathing needs were met, and continuous ongoing recruitment and job fairs. (528)

PLEASE NOTE: This non-compliance was issued as a result of Complaint Log # 005152-18, which was completed concurrently with the Resident Quality Inspection log #023251-18.

K. The severity of this issue was determined to be risk of harm 2 as there was minimal harm to the resident. The scope of the issue was pattern 2. The home had a level 2 history of non related non-compliance. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 03, 2019

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

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

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

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

Attention Registrar 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.

2007, c. 8 L. O. 2007, chap. 8

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 27th day of June, 2019 (A4)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by CYNTHIA DITOMASSO (528) - (A4)

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