

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

**Rapport d'inspection en vertu de  
la Loi de 2007 sur les foyers de  
soins de longue durée**

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

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

Hamilton Service Area Office  
119 King Street West 11th Floor  
HAMILTON ON L8P 4Y7  
Telephone: (905) 546-8294  
Facsimile: (905) 546-8255

Bureau régional de services de  
Hamilton  
119, rue King Ouest 11<sup>ième</sup> étage  
HAMILTON ON L8P 4Y7  
Téléphone: (905) 546-8294  
Télécopieur: (905) 546-8255

**Public Copy/Copie du rapport public**

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<b>Report Date(s) / Date(s) du Rapport</b>	<b>Inspection No / No de l'inspection</b>	<b>Log # / No de registre</b>	<b>Type of Inspection / Genre d'inspection</b>
Sep 17, 2021	2021_689586_0023	007096-21, 009443-21	Critical Incident System

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**Licensee/Titulaire de permis**

AXR Operating (National) LP, by its general partners  
c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W  
0E4

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

Ridgeview  
385 Highland Road West Stoney Creek ON L8J 3X9

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

JESSICA PALADINO (586)

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**Inspection Summary/Résumé de l'inspection**

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**The purpose of this inspection was to conduct a Critical Incident System inspection.**

**This inspection was conducted on the following date(s): September 7, 8, 9 and 10, 2021.**

**Inspectors #694267 and #706988 were present and shadowing during the inspection.**

**The following Critical Incident System (CIS) inspections were conducted concurrently, 007096-21 (CIS #2849-000006-21) and 009443-21 (CIS #2849-000007-21), both related to the prevention of abuse and neglect.**

**During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Resident Services Co-ordinator (RSC), Environmental Services Manager (ESM), registered nurses (RN), registered practical nurses (RPN), personal support workers (PSW), housekeeping staff and residents.**

**During the course of the inspection, the inspector(s) toured the home, completed mandatory Infection Prevention and Control (IPAC) and cooling requirement checklists, observed resident care and reviewed resident records, relevant policies and procedures, internal investigation notes, program evaluations, and education materials.**

**The following Inspection Protocols were used during this inspection:  
Hospitalization and Change in Condition  
Infection Prevention and Control  
Prevention of Abuse, Neglect and Retaliation  
Safe and Secure Home**

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

**1 WN(s)**

**1 VPC(s)**

**1 CO(s)**

**0 DR(s)**

**0 WAO(s)**

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a resident was protected from neglect by a staff member.

Ontario Regulation 79/10, s. 5, defines "neglect" as 'the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents'.

A resident was found deceased. Through the home's internal investigation, it was discovered that a staff member responsible for the resident's care did not provide care to the resident required for safety. The staff member did not fully complete all required safety checks, did not audit the resident's fall prevention intervention which happened to not be working and did not report a change in the resident's health status.

The above information was confirmed by the staff member through the home's internal investigation as well as through interview with the Long-Term Care Homes (LTCH) Inspector.

The home's internal investigation concluded that the inaction by the staff member met the definition of neglect. This was also acknowledged through interview with the RSC.

The pattern of inaction by the staff member jeopardized the resident's safety.

Sources: CIS report, the resident's clinical health record, the home's internal investigation notes, the licensee's policy 'LTC - Safety Rounds' (CARE10-O10.05; reviewed March 31, 2021), the licensee's Job Routines - 'PSW, NIGHTS' and interviews with staff. [s. 19. (1)]

2. The licensee has failed to ensure that a resident was protected from emotional abuse by a staff member.

Ontario Regulation 79/10, s. 2.1, 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'.

A resident was refused to be taken to the washroom by a staff member. The incident

was witnessed. This information was confirmed by the staff member through the home's internal investigation as well as through interview with the LTCH Inspector.

The home's internal investigation concluded that the staff member's words and actions met the definition of emotional abuse. This was also acknowledged through interview with the DOC.

The failure to comply with a resident's request to be toileted without reason and the comment the staff member used was a form of infantilization.

Sources: CIS report, the resident's clinical health record, the home's internal investigation notes and interviews with staff. [s. 19. (1)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident is protected from emotional abuse by anyone, to be implemented voluntarily.***

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Issued on this 20th day of September, 2021

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

**Original report signed by the inspector.**

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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 Operations Division  
Long-Term Care Inspections Branch

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

**Public Copy/Copie du rapport public**

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**Name of Inspector (ID #) /**

**Nom de l'inspecteur (No) :** JESSICA PALADINO (586)

**Inspection No. /**

**No de l'inspection :** 2021\_689586\_0023

**Log No. /**

**No de registre :** 007096-21, 009443-21

**Type of Inspection /**

**Genre d'inspection:** Critical Incident System

**Report Date(s) /**

**Date(s) du Rapport :** Sep 17, 2021

**Licensee /**

**Titulaire de permis :** AXR Operating (National) LP, by its general partners  
c/o Revera Long Term Care Inc., 5015 Spectrum Way,  
Suite 600, Mississauga, ON, L4W-0E4

**LTC Home /**

**Foyer de SLD :** Ridgeview  
385 Highland Road West, Stoney Creek, ON, L8J-3X9

**Name of Administrator /**

**Nom de l'administratrice**

**ou de l'administrateur :** Mary Wariara

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To AXR Operating (National) LP, by its general partners, you are hereby required to  
comply with the following order(s) by the date(s) set out below:

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

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

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l'article 154 de la *Loi de 2007 sur les  
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2007, chap. 8

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

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

**Order / Ordre :**

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

Specifically, the licensee shall ensure that all residents are protected from neglect. The licensee shall:

-Perform weekly audits on the identified staff member to ensure they are providing appropriate care to residents on the scheduled shift; and,

-Document the audits and continue auditing until no further concerns arise with the staff member providing adequate care to residents in accordance with the home's policies. The audits are to be maintained for LTCH Inspector review.

**Grounds / Motifs :**

1. The licensee has failed to ensure that a resident was protected from neglect by a staff member.

Ontario Regulation 79/10, s. 5, defines "neglect" as 'the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents'.

A resident was found deceased. Through the home's internal investigation, it was discovered that a staff member responsible for the resident's care did not provide care to the resident required for safety. The staff member did not fully complete all required safety checks, did not audit the resident's fall prevention intervention which happened to not be working and did not report a change in the resident's health status.

**Order(s) of the Inspector**

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foyers de soins de longue durée*, L.O.  
2007, chap. 8

The above information was confirmed by the staff member through the home's internal investigation as well as through interview with the Long-Term Care Homes (LTCH) Inspector.

The home's internal investigation concluded that the inaction by the staff member met the definition of neglect. This was also acknowledged through interview with the RSC.

The pattern of inaction by the staff member jeopardized the resident's safety.

Sources: CIS report, the resident's clinical health record, the home's internal investigation notes, the licensee's policy 'LTC - Safety Rounds' (CARE10-O10.05; reviewed March 31, 2021), the licensee's Job Routines - 'PSW, NIGHTS' and interviews with staff. [s. 19. (1)]

An order was made by taking the following factors into account:

Severity: There was actual risk of harm to the resident.

Scope: This non-compliance was a pattern as two of three residents reviewed resulted in non-compliance with this section of the legislation. A voluntary plan of correction (VPC) was issued during this inspection related to resident #002 and can be found in the licensee report under WN #1.

Compliance History: There was a VPC issued in the same area of the legislation in the past 36 months. (586)

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

Oct 08, 2021



**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

Pursuant to section 153 and/or  
section 154 of the *Long-Term  
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2007, c. 8

Aux termes de l'article 153 et/ou de  
l'article 154 de la *Loi de 2007 sur les  
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2007, chap. 8

**REVIEW/APPEAL INFORMATION**

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8th Floor  
Toronto, ON M7A 1N3  
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:

**Order(s) of the Inspector**

**Ordre(s) de l'inspecteur**

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

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

Health Services Appeal and Review Board and the Director

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

Director  
c/o Appeals Coordinator  
Long-Term Care Inspections Branch  
Ministry of Long-Term Care  
438 University Avenue, 8th Floor  
Toronto, ON M7A 1N3  
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](http://www.hsarb.on.ca).

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**Ordre(s) de l'inspecteur**

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2007, c. 8

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l'article 154 de la *Loi de 2007 sur les  
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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 des Soins de longue durée  
438, rue University, 8<sup>e</sup> étage  
Toronto ON M7A 1N3  
Télécopieur : 416-327-7603

**Order(s) of the Inspector****Ordre(s) de l'inspecteur**

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

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l'article 154 de la *Loi de 2007 sur les  
foyers de soins de longue durée*, L.O.  
2007, chap. 8

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 révision  
des services de santé  
151, rue Bloor Ouest, 9e étage  
Toronto ON M5S 1S4

Directeur  
a/s du coordonnateur/de la coordonnatrice en matière  
d'appels  
Direction de l'inspection des foyers de soins de longue durée  
Ministère des Soins de longue durée  
438, rue University, 8e étage  
Toronto ON M7A 1N3  
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](http://www.hsarb.on.ca).

**Issued on this 17th day of September, 2021**

**Signature of Inspector /**

**Signature de l'inspecteur :**

**Name of Inspector /**

**Nom de l'inspecteur :** Jessica Paladino

**Service Area Office /**

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