Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

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

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| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Sep 11, 2017 | 2017_527665_0004 | 017896-16, 019423-16, 026264-16, 031978-16, 034624-16, 034863-16, 035373-16, 000242-17, 000954-17, 004149-17, 005112-17, 006676-17, 007825-17 | Complaint |

**Licensee/Titulaire de permis**

RYKKA CARE CENTRES LP
3200 Dufferin Street Suite 407 TORONTO ON M6A 3B2

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

HAWTHORNE PLACE CARE CENTRE
2045 FINCH AVENUE WEST NORTH YORK ON M3N 1M9

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

JOY IERACI (665), JENNIFER BROWN (647), JOVAIRIA AWAN (648), SARAH KENNEDY (605)

## Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): April 19, 20, 21, 24, 25, 26, 27 and 28, 2017 and May 1, 2, 4, 5, 8, 9, 10, 11, 12, 15, 16, 17, 18, 19, 23, 24, 25, 26, 29 and 30, 2017.**

**Inspector Shihana Rumzi (604) is included in this Inspection.**

**The following Complaint Intakes were inspected:**
**- Log #017896-16 related to falls prevention and pain management**
**- Log #000242-17 related to laundry service**
**- Logs #031978-16, #000954-17 and #005112-17, #07825-17 related to skin and wound care**
**- Log #010160-17 related to Leave of Absence**
**- Logs #019423-16, #006676-17, #034863-16, #026264-17 and #004149-17 related to alleged staff to resident abuse**
**- Log #034624-16 related to foot and nail care, resident to resident altercations**
**- Log #035373-16 related to nutritional care and hydration programs, continence care and bowel management, responsive behaviours**

**The following Complaint intakes were inspected by Inspector #604:**
**- Log #031978-16, Log #000954-17, Log #005112-17 and Log #07825-17 related to skin and wound care**
**- Log #010160-17 related to Leave of Absence**
**- Log #017896-16 related to Falls prevention and Pain Management**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Interim Director of Care (IDOC), Assistant Director of Care (ADOC), Special Projects Nurse (SPRN), Quality Coordinator (QC), Social Worker (SW), Resident Assessment Instrument (RAI) Coordinator, Registered Dietician (RD), Environmental Services Manager (ESM), Finance Clerk (FC), Dietary Manager (DM), Physiotherapists (PT), Responsive Behaviour Lead (RBL), Convalescent Care Coordinator RN (CCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Physiotherapy Assistant (PTA), Personal Support Workers (PSW), Housekeeper (HK), Capacity Assessor (CA), Residents and Families.**

**The inspectors also conducted dining observations, staff and resident interactions, provision of care observations, reviewed clinical health records, relevant home policies and procedures, staff training records and other pertinent documents.**

**The following Inspection Protocols were used during this inspection:**

**Accommodation Services - Laundry**
**Continence Care and Bowel Management**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Medication**
**Nutrition and Hydration**
**Pain**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**
**Skin and Wound Care**

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

- **10 WN(s)**
- **3 VPC(s)**
- **3 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records**

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

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

**Findings/Faits saillants :**

The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

O. Reg.79/10, s. 30 (1) (1), Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1) (1).

1. The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in2016, alleging staff to resident abuse for resident #012. The CIS report indicated the resident's family member reported that he/she observed multiple areas of altered skin integrity on identified body areas on resident #012. The family member also submitted complaints regarding the same matter on identified dates in 2016, through the MOHLTC ActionLine.

Interview with the complainant identified that he/she reported that on the date of the alleged abuse, he/she noticed areas of altered skin integrity on two areas of resident #012's body. The complainant stated he/she had noticed the altered skin integrity on previous visits. The complaint acknowledged medication was known to cause altered skin integrity, however was not satisfied with the home's response related to this particular incident.

Record review of the home's Skin Care and Wound Management Program manual for Responsive Health Management (Revised April 2010) indicated Personal Support Workers (PSW) were to report the identified areas of skin integrity to the unit supervisor, document skin integrity every shift, and ensure that there is documented evidence that the PSW promotes skin integrity.

Review of resident #012's clinical records identified the home initiated a treatment administration record (TAR) five days after the identified altered skin integrity were noted. The TAR directed staff to monitor resident's skin daily for the identified skin integrity alterations and document in Point Click Care (PCC) under skin and wound.

Interviews with PSW #100 revealed that PSW staff were to monitor resident's skin every morning and report new skin changes including the areas of altered skin integrity to registered staff. PSW #100 reported he/she was aware of resident #012's ongoing identified altered skin integrity but was unable to confirm if he/she had reported it to registered staff.

Interview with PSW #189 revealed he/she was assigned to resident #012 on an identified date in 2016. PSW #189 reported he/she had observed the identified areas of altered skin integrity on resident #012's identified body area but had not reported it to the registered staff.

PSW #100 and PSW #189 revealed resident #012 was known for having identified responsive behaviours and suggested this as a contributing factor to the ongoing identified areas of altered skin integrity.

Interview with Registered Practical Nurse (RPN) #167 revealed the home's expectation is for PSW staff to report the identified altered skin integrity on resident's skin to registered staff.

Interview with the Skin and Wound Lead (SWL) #116 revealed PSW staff are expected to report the identified areas of altered skin integrity or changes in skin to registered staff on an ongoing basis. Review of resident #012's written plan of care with Registered Nurse (RN) #116 revealed it did not clearly identify residents' history of the ongoing identified altered skin integrity, contributing medical conditions, or contributing responsive behaviors despite direct care staff reporting otherwise. RN #116 confirmed PSW staff did not meet the home's expectation for monitoring skin changes as resident #012's known history of the identified altered skin integrity was not captured in the plan of care, and documented and assessed as per the home's Skin Care and Wound Management Program.

Interview with Associate Director of Care (ADOC) #156 revealed direct care staff are directed to immediately report changes in skin condition including the altered skin integrity alteration to registered staff. Record review of resident #012's progress notes with ADOC #156 identified that the ongoing altered skin integrity on resident #012's was not documented for 2016, prior to the date of the alleged abuse.

2. The MOHLTC, ACTIONline received a complaint on an identified date in 2017, from resident #021's Substitute Decision Maker (SDM). The SDM indicated resident #021

developed an identified altered skin integrity during a particular month in 2016, and had not been notified. The resident was transferred to hospital on an identified date in 2017, and the hospital informed the SDM of the identified altered skin integrity and another area of altered skin integrity.

A review of resident #021's PCC progress note on an identified date in 2016, indicated resident had an identified area of altered skin integrity that had deteriorated, the PCC note had no description of the identified altered skin integrity and the physician ordered an identified intervention to promote healing.

A review of the home's policy "Skin Care & Wound Management" program, "The Role of the Unit supervision (RN/RPN), under procedure number seven, directed the staff to notify the Skin Care coordinator and Registered Dietitian when there is skin breakdown present, the SDM and physician.

Interview with RPN #142 indicated when there is an area of altered skin integrity identified for a resident, a skin and wound care referral is to be sent to the home's SWL in order to have the resident's skin be assessed. The RPN confirmed he/she documented a progress note on an identified date in 2016, when he/she found the area of altered skin integrity on resident #021's identified body area. The RPN reviewed the progress notes for resident #021 and indicated he/she did not send a skin and wound care referral to the SWL when the resident's identified area of altered skin integrity had deteriorated as per the home's policy and procedures.

Interviews carried out with the home's SWL #116 and the Interim Director of Care (IDOC) #156 indicated it was the home's policy for a referral to be sent to the home's SWL in order for the skin issue to be assessed. The SWL and IDOC reviewed resident #021's progress notes and confirmed when resident #021's identified area of altered skin integrity had deteriorated, a referral was not sent to the SWL as per the home's policy. [s. 8. (1)]

3. The MOHLTC, ACTIONline received a call on an identified date in 2017, from resident #021's SDM. The SDM indicated resident #021 developed an identified area of altered skin integrity on an identified date in 2016, and had not been notified of the area of altered skin integrity . The resident was transferred to hospital on an identified date in 2017, and the hospital informed the SDM of two areas of identified altered skin integrity.

Interviews conducted with resident #021's SDM #113 indicated the home did not inform

him/her of the resident having an identified area of skin integrity on an identified body area. The SDM stated he/she was unaware of the identified area of altered skin integrity to the identified body area.

A review of the home's policy "Skin Care & Wound Management" program, "The Role of the Unit supervision (RN/RPN), under procedure number seven directed the staff to notify the Skin Care coordinator and Registered Dietitian when there is skin breakdown present, the SDM and physician.

A review of resident #021's PCC progress note on an identified date in 2016, indicated resident had an identified area of altered skin integrity on an identified body area and the PCC note did not identify the assessed condition of the area of altered skin integrity and the physician ordered an identified intervention to promote healing.

Interview with RPN #142 indicated it is the home's policy to contact the SDM when there is skin breakdown. The RPN confirmed he/she documented a progress note on an identified date in 2016, as he/she found an an area of altered skin integrity on resident #021's. RPN #142 was not able to recall if the SDM had been notified of the identified area of altered skin integrity as per the home's policy and procedures.

Interviews carried out with the home's SWL #116 and the IDOC #156 indicated it was the home's policy for the family be called at the time when altered skin integrity was identified to ensure the family was aware of the health status of the resident. The SWL and IDOC confirmed after they reviewed the progress notes of resident #021 on PCC and they did not find evidence of the SDM being informed on an identified month regarding the identified area of altered skin integrity. The SWL and the IDOC stated the home's policy to inform the SDM's when altered skin integrity was identified was not followed.

4. On March 3, 2017, MOHLTC ACTIONline received a complaint involving resident #022. The complainant stated resident #022 was transferred to hospital as there was a change in his/her health status. The complainant indicated he/she was notified by the hospital that resident #022 had an identified area of altered skin integrity and questioned as to why the identified area of altered skin integrity was not treated. The POA indicated he/she met with the home's administrator who indicated the resident would be cared for.

A review of the PCC progress notes revealed a note on an identified date in 2016, stated resident #022's identified area of altered skin integrity had deteriorated , treatment applied and it would be endorsed to all shifts to continue with treatment.

A review of the Pixler skin assessment program, the skin assessment carried out on an identified date in 2016, identified resident #022's identified area of altered skin integrity.

Interviews conducted with resident #022's SDMs #135 and #136 indicated the home did not inform them of the resident having the identified area of altered skin integrity. SDM #135 indicated the home should have informed him/her of the resident's declining area of altered skin integrity.

A review of the home's policy "Skin Care & Wound Management" program, "The Role of the Unit supervision (RN/RPN), under procedure number seven directs the staff to notify the Skin Care coordinator and Registered Dietitian when there is skin breakdown present, the SDM and physician.

Interview with RPN #104 confirmed he/she documented a progress note on an identified date in 2016, when he/she found the identified area of altered skin integrity on resident #022's body and did not recall calling the family of resident #022 to inform them of the area of altered skin integrity as per the home's policy and procedures.

Interviews carried out with the home's SWL #116 and the IDOC #156 indicated it was the home's policy the family be called at the time when an area of altered skin integrity was identified to ensure the family was aware of the health status of the resident. The SWL and IDOC confirmed after they reviewed the progress notes of resident #022 on PCC that they did not find evidence of the SDM being informed in an identified month after the identified area of altered skin integrity was identified and acknowledged the staff did not identify a specific characteristic of the identified area of altered skin integrity. The SWL and the IDOC stated the home's policy to inform the SDM when an area of altered skin integrity was identified was not followed.

5. The MOHLTC ACTIONline received a complaint on an identified date in 2016, by a complainant from a hospital who was caring for resident #023. The complainant indicated he/she had concerns that the home may not have provided identified skin care for resident #023 as the resident had an identified number of areas of altered skin integrity. The complainant stated resident was under treatment for an identified condition, and alleged that the home did not provide appropriate skin treatments.

A review of the home's "Skin Care & Wound Management Program", Quality Management the role of other members of the interdisciplinary team directs staff under

procedure number five: Receives referrals from the registered staff and/or physician and assesses all residents with identified areas of altered skin integrity.

A review of resident #023's admission notes on PCC indicated the resident was admitted to the home in 2016, with an identified number of areas of altered skin integrity to identified body areas, no other information had been documented related to the identified areas of altered skin integrity.

Interviews with RN #118 and the SWL stated that once a resident is identified with areas of altered skin integrity , a skin and wound referral is to be sent to the home's SWL through PCC as soon as possible. The RN reviewed resident #023's PCC notes and indicated that on admission, resident #023, was identified as having an identified number of ares of altered skin integrity and he/she was unable to locate a skin and wound referral being sent to the home's SWL.

Interview with the Director of Care (DOC) stated registered staff are expected to send skin and wound referrals to the home's SWL once a resident is identified to areas of altered skin integrity. The DOC conducted a review of resident #023's PCC notes and indicated that a referral for resident #023's identified areas of altered skin integrity was not sent as per home's policy. [s. 8. (1)]

6. The MOHLTC ACTIONline received a complaint on an identified date in 2016, regarding resident #001. The complainant indicated resident #001 sustained an identified injury to resident #001's body and complained of pain. As per intake, complainant was concerned about the increase in falls the resident had and the overall care resident received.

O. Reg.79/10, s. 30 (1) (1), Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1) (1).

A review of the home's Falls Prevention Program with a Revised date of March 2014, indicated, under the Post Fall Assessment Policy, number five of the procedure, "Notify the physician immediately and provide him/her with the assessment, vital signs and the

clinical symptoms of the evidence of the injury, and also notify the substitute decision maker (family)."

On an identified date in 2016, resident #001 had an unwitnessed fall. Record review of resident #001's progress notes revealed the outgoing registered staff endorsed to the incoming registered staff to notify the SDM of resident #001's fall incident. Further review of the progress notes found the SDM was notified of the fall two days after the incident, when resident #001 was transferred to hospital as a result of the fall.

Interview with RN #125 indicated it is the home's expectation for a SDM to be notified immediately when a resident has a fall. RN #125 acknowledged that he/she was to notify resident #001's SDM on the day of the fall, after the identified nurse endorsed the task to him/her. RN #125 stated he/she did not follow the home's expectation of notifying resident #001's SDM regarding the fall.

Interview with the ADOC/Fall Prevention Lead #106 indicated it is the home's expectation for a resident's SDM be notified within the same day when a resident has a fall. ADOC #106 reviewed the clinical record of resident #001 and acknowledged resident #001's SDM was not notified until two days later, when resident was being transferred to hospital as a result of the fall. ADOC #106 indicated the staff did not follow home's policy regarding notification of resident #001's fall to his/her SDM.

Interview with the IDOC #156 indicated as part of the home's falls program, the SDMs are to be notified as soon as possible when a resident has a fall. IDOC #156 reviewed the clinical records of resident #001 and acknowledged resident's SDM was not notified until two days later, when resident was being transferred to hospital as a result of the fall. IDOC #156 stated the staff did not follow the home's falls program regarding notifying the SDM of resident #001.

The home is being served an order as the home did not comply with their policies and procedures on Skin and Wound for four identified residents and Falls Prevention for one identified resident.  Resident #012 had identified ares of altered skin integrity which was not reported to the registered staff by the PSWs and the staff did not document skin integrity for the resident as per home's policy. Resident #021's identified area of altered skin integrity had deteriorated and the home did not send a referral to the SWL and the SDM was not notified of the skin breakdown as per home's policy. Resident #022 had an area of altered skin integrity that had deteriorated as per progress note on an identified date in 2016, the SDM was not notified of the area of altered skin integrity as per home's

policy. Resident #023 was admitted to the home on in 2016, with an identified number of areas of altered skin integrity. A skin and wound referral was not sent to the SWL to assess the areas of altered skin integrity as per the home's policy. Resident #001 had an unwitnessed fall, and the SDM was not notified until the resident was transferred to hospital two days after, for further assessment as a result of the fall.

The severity of the non-compliance and the severity of harm and risk was potential for actual harm as:

- Resident #012's identified areas of altered skin integrity were not reported to the registered staff and skin integrity documentation was not completed
- SDMs of residents' #021 and #022 were not notified of the residents' areas of altered skin integrity
- Referrals to the home's SWL were not sent for residents #021 and #023
- SDM of resident #001 was not notified of a the resident's fall until the day the resident was transferred to hospital, two days later

The scope of the non-compliance was a pattern.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, O. Reg. 79/10, s. 8. (1), was issued.
The Non-compliances are as follows:

- 2016_382596_0004, Resident Quality Inspection - VPC was issued.
- 2015_268604_0011, Resident Quality Inspection - VPC was issued.

***Additional Required Actions:***

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

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**WN #2: 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,**
**(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; O. Reg. 79/10, s. 50 (2).**

**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 :**

The licensee has failed to ensure that the resident received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

1. The MOHLTC ACTIONline received a complaint on an identified date in 2016, by a complainant who was caring for resident #023 at the hospital. The complainant indicated he/she had concerns of inadequate skin care for resident #023 as the resident had an identified number of areas of altered skin integrity to identified body areas. The complainant stated the resident was under treatment for an identified medical condition, and alleged that the home did not provide skin care treatments.

A review of resident #023's admission notes on PCC indicated the resident was admitted to the home on an identified date in 2016, with identified areas of altered skin integrity

with no other information provided related to the areas of altered skin integrity characteristics.

Interview with RN #118 stated it was the home's expectation that a skin assessment was to be completed on Pixler the homes skin assessment tool immediately when a resident is admitted with areas of altered skin integrity. The RN reviewed resident #023's PCC notes and confirmed he/she carried out the admission for resident #023. The RN reviewed Pixler and indicated a skin assessment was not carried out within 24 hrs of admission for resident #023 and a skin assessment was only carried out seven days later by the home's SWL.

Interview with the home's SWL #116 stated when a resident is admitted to the home with the identified areas of altered skin integrity, the registered staff is to carry out a skin assessment on Pixler which will create a skin and wound profile for the newly admitted resident and then inform him/her of the identified areas of altered skin integrity. The SWL indicated that a review of the admission note stated resident #023 had the identified number of areas of altered skin integrity with no other characteristics of the areas of altered skin integrity documented. A review of Pixler showed that a skin assessment on the identified areas of altered skin integrity for resident #023 had been conducted on an identified date, seven days after the resident's admission date by the SWL.

Interview with the home's IDOC indicated it is the home's expectation that a skin assessment be completed on Pixler immediately when a resident is admitted with areas of altered skin integrity. The IDOC reviewed resident #023's PCC notes and Pixler and stated that resident #023 was admitted with the identified areas of altered skin integrity and a skin assessment had not been completed within 24 hours of admission as required.

2. The licensee had failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered staff upon return from hospital.

The MOHLTC, ACTIONline received a complaint on an identified date in 2017, from resident #021's SDM. The SDM indicated resident #021 developed an identified area of altered skin integrity on an identified month in 2016, and he/she had not been notified of the altered skin integrity. The resident was transferred to hospital on an identified date in 2017, and the hospital informed the SDM of the identified altered skin integrity.

A review of resident #021's PCC progress notes indicated that on an identified date in 2017, the resident was transferred to hospital due to a significant change to resident's identified altered skin integrity, discovery of a new altered skin integrity on an identified number of sites on resident #021's body. Further review of the progress notes indicated the resident was readmitted to the home on an identified date in 2017 and diagnosed with an identified medical concern. The note indicated resident #021 had an identified altered skin integrity with no description of the site.

A review of resident #021's documentation did not reveal that a skin assessment had been completed by registered staff when the resident was readmitted to the home from hospital on the identified date in 2017. A skin assessment on the Pixler program was documented on an identified date in 2017, which identified the altered skin integrity's type, nine days later.

Interviews conducted with the SLW #116 and IDOC #156, indicated it was the home's expectation a head to toe assessment be carried out on readmission from hospital and a Pixler skin assessment be completed when the identified area of altered skin integrity is identified. The SLW and IDOC reviewed PCC and the Pixler program and indicated a skin assessment had not been completed for resident #021 on readmission from hospital and a skin assessment was only carried out nine days later which revealed the identified the altered skin integrity's type.

3. The licensee has 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 MOHLTC ACTIONline received a complaint related to resident #022 on an identified date in 2017. The complainant stated resident #022 was transferred to hospital as there was a change in his/her health status. The complainant was notified that the resident had an identified area of altered skin integrity and was questioned by the hospital as to why the identified area of altered skin integrity was not treated. The POC indicated he/she met with the home's administrator who indicated the resident would be cared for.

A review of the PCC progress notes revealed a note on an identified date in 2016, which stated resident #022's identified area of altered skin integrity had deteriorated, treatment provided and it would be endorsed to all shift to continue with treatment. The progress note did not give any characteristics of the identified area of altered skin integrity.

In another progress note on an identified date in 2017, resident #022 was transferred to an identified hospital. On an identified date in 2017, readmission from hospital progress notes created by RPN #140 did not give characteristics of the identified skin breakdown. Further review of the progress notes revealed a progress note six days later indicating, a skin assessment for resident #022 was completed and found to have an identified area of altered skin integrity with characteristics identified.

Interview with RPN #104 confirmed the home utilized the Pixler program to document skin assessments on areas of altered skin integrity. The RPN stated he/she documented the progress note on an identified date in 2016, when he/she found the identified area of altered skin integrity on resident #022 and did not document characteristics of the site. The RPN indicated he/she did not document a skin assessment on Pixler program for resident #022's identified area of altered skin integrity.

Interviews carried out with the home's SWL #116 and the home's IDOC #156 indicated the tool the home utilizes for documenting skin assessments was the Pixler program. The SWL and IDOC indicated it was an expectation when a resident is readmitted from hospital and when an the identified area of altered skin integrity is identified on readmission from hospital, a skin assessment is to be carried out on the Pixler program. They indicated the Pixler program is to be used when a skin conditions such as areas of altered skin integrity is identified on a resident. The SWL and the IDOC indicated that on the identified date in 2016, resident #022 was identified with an area of altered skin integrity. The SWL stated he/she carried out a skin assessment on Pixler on an identified date in 2016, seven days later and found the identified area of altered skin integrity with an identified characteristic. The SWL and the IDOC stated the resident's identified area of altered skin integrity would show a change of condition and when this change was identified by the RPN, the RPN should have used Pixler program to create a profile and a skin assessment for resident #022 should have been done on the home's skin assessment tool Pixler, which was not done. After the SWL and IDOC reviewed the progress notes the SWL and the IDOC confirmed that upon readmission from hospital of resident #022, he/she did not receive a skin assessment when he/she was identified as having the identified altered skin integrity as per the progress note and a skin assessment was carried out six days later on an identified date in 2017 in the Pixler program.

4. The licensee of a long-term care home shall ensure that the resident exhibiting altered

skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive immediate treatment to promote healing.

The MOHLTC ACTIONline received a complaint on an identified date in 2016, by a complainant from a hospital who was caring for resident #023. The complainant indicated he/she had concerns that the home may not have provided identified skin care for resident #023 as the resident had an identified number of areas of altered skin integrity.

A review of resident #023's admission notes on Point Click Care (PCC) indicated the resident was admitted to the home on an identified date in 2016 with an identified number of areas of altered skin integrity and no other information was provided related to identified areas of altered skin integrity characteristics.

A review of resident #023's Medication Administration Records (MARS) and Treatments Administration Records (TARS) for an identified month in 2016, revealed a physician order for the identified areas of altered skin integrity with an identified start date. There were "X"s for an identified period of days in the identified month indicating no treatment being carried out. A review of resident #023's PCC notes, did not show any evidence of any treatment being carried out for resident #023's identified areas of altered skin integrity for the identified period of days.

Interviews with RN #118 and the home's SWL confirmed resident #023 was admitted to the home on with identified number of areas of altered skin integrity to his/her body and a review of the MARS and TARS indicated that there was no care or treatment being provided to the identified areas of altered skin integrity from the identified period of days. RN #118 stated an "X" means that no care or treatment was provided and care for the identified areas of altered skin integrity was only started on an identified date in 2016. The SWL stated that he/she was unable to find a treatment order for the identified areas of altered skin integrity for resident #023.

Interview with IDOC #156, stated resident #023 was admitted to the home with identified number of areas of altered skin integrity. The IDOC reviewed resident #023's MARS and TARS for an identified month in 2016, PCC notes from the identified period of days in 2016, and skin assessments carried out on Pixler and acknowledged he/she was unable to find evidence to show that the home provided any care or treatment to the resident's identified number of areas of altered skin integrity since admission. The IDOC acknowledged that the SWL only assessed the identified number of areas of altered skin integrity seven days later when the identified areas of altered skin integrity were at an

identified characteristic and then put a treatment plan in place to care for the identified areas of altered skin integrity for resident #023's identified areas of altered skin integrity.

The severity of the non-compliance and the severity of harm and risk was actual.

-On an identified date in 2016, resident #023 was admitted to the home with identified number of areas of altered skin integrity, there was no evidence to show that the home carried out a skin assessment or treatments on the resident's areas of altered skin integrity until seven days later, when the identified areas of altered skin integrity were at an identified chararcteristic.

-On an identified date in 2017, resident #021 was transferred to hospital due to a significant change to resident's identified altered skin integrity, discovery of a new altered skin integrity on an identified number of sites on resident #021's body. The resident was readmitted to the home on an identified date in 2017 and diagnosed with an identified medical condition. The note indicated resident #021 had an identified altered skin integrity with no description of the site. A skin assessment was documented nine days later, which identified the characteristic of the identified altered skin integrity.

-On an identified date in 2017, resident #022 was transferred to an identified hospital. A readmission from hospital progress notes created by RPN #140 did not give characteristics of the identified area of altered skin integrity. Further review of the progress notes revealed a progress note six days later indicating, a skin assessment for resident #022 was completed and found to have an identified area of altered skin integrity with characteristics identified.

- A progress note on an identified date, stated resident #022's identified area of altered skin integrity had reopened and the progress note did not give any characteristics of the identified area of altered skin integrity. On an identified date in 2016, seven days later, the skin assessment of the identified area of altered skin integrity was found to be at an identified characteristic.

The scope of the non-compliance was a pattern.

A review of the home's compliance history revealed no previous non-compliance related to the Long-Term Care Homes Act, Or.Reg c. 8, s. 50. (2) (a) (i), (ii), and s. 50. (2) (b) (i), which was issued. [s. 50. (2) (b) (i)]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents**
**Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,**
**(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and**
**(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.**

**Findings/Faits saillants :**

The licensee has failed to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents and in identifying and implementing interventions.

The home submitted CIS report on an identified date in 2016 through the after-hours pager indicating resident #014 exhibited an identified responsive behaviour toward resident #013 on their home area. Resident #013 was subsequently sent to hospital following assessment and returned to the home on an identified date in 2016 with a diagnoses and treatment of an identified injury.

Record review of resident #014's written plan of care on an identified date, identified he/she had identified responsive behaviours toward co-residents. Interventions reviewed in the written plan of care did not identify direction to staff to minimize risk of altercation of resident #014 with co-residents on the identified resident home area. Further review of resident #014's clinical records identified six documented incidents of the identified responsive behaviour with co-residents over a six month period in 2016 on the identified resident home area.

Interview with PSW's #183, #161, and #168 revealed resident #014 was known to staff for identified responsive behaviours directed to co-residents on the identified resident home area, and identified he/she was a safety risk to other residents on the unit due to a history of identified interactions with co-residents. PSW's #183, #161, and #168 did not identify interventions available to staff to minimize the risk of altercations between resident #014 and co-residents in the identified resident home area.

Interview with PTA #153 identified resident #014 was known to staff to exhibit an identified responsive behaviour. PTA#153 identified the co-resident involved in the identified interaction with resident #014 on an identified date in 2016, sustained a fall following the identified interaction. PTA#153 reported he/she responded to the identified interaction between resident #014 and #013 on an identified date in 2016. PTA #153 reported he/she saw resident #014 standing by resident #013 in an identified area of the resident home area's hallway. PTA#153 reported resident #013 stated resident #014 had interacted with him/her.

RN #147 was identified to be on duty on the identified date in 2016, at that time of the reported incident in the identified resident home area. Interview with RN #147 revealed he/she did not witness the identified interaction between resident #014 and #013. RN #147 revealed resident #014 was known to have the identified responsive behaviour and a known history of identified altercations with co-residents on the identified resident home area. RN #147 stated that resident #014 remained a safety risk to co-residents on the identified resident home area. RN #147 did not identify interventions available to staff to minimize the risk of the identified interactions between resident #014 and co-residents in the resident home area.

Interview with the behavioural support RPN #159 revealed resident #014 was known to him/her to have an identified responsive behaviour and had a known history of identified interactions with co-residents on the identified resident home area. RPN #159 identified resident #014 was a safety risk to co-residents on the unit due to the known history reviewed above. RPN #159 did not identify interventions available to staff to minimize the risk of the identified interactions between resident #014 and co-residents in the resident home area.

Interview with RN #118 and ADOC #156 revealed their awareness of resident #014's responsive behaviours towards co-residents. RN #118 indicated that resident #014 was a safety risk to co-residents on the unit. RN #118 and ADOC #156 did not identify interventions available to staff to minimize the risk of the identified interactions between

resident #014 and co-residents in the identified resident home area. ADOC #156 further revealed no other staff were in an identified area of the resident home area to monitor residents at the time of the incident on an identified date in 2016.

Interview with the ED acknowledged the home had not considered appropriate interventions and steps to mitigate the risk of resident #014's identified responsive behaviours to co- residents on the identified resident home area.

Interviews with ADOC #156 and ED were unable to demonstrate that the home had ensured that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #014 and co-residents in the identified resident home area by identifying and implementing interventions.

The home is being served an order as the home had not identified and implemented interventions and steps to mitigate the risk of resident #014's identified responsive behaviours to co-residents on the identified resident home area. Resident #014 had known responsive behaviours and identified interactions towards co-residents on the identified resident home area. Staff interviewed indicated resident #014 was a safety risk to other residents in the unit due to his/her responsive behaviours. Documentation in the home's clinical records for resident #014 indicated incidences when there were identified interactions with co-residents on the identified resident home area.

The severity of the non-compliance and the severity of harm and risk was actual as resident #014 had six documented responsive behaviour altercations with co-residents over a six month period in 2016.

The scope of the non-compliance was isolated.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, O. Reg. 79/10, s. 54 (b), was issued.
The Non-compliance are as follows:

- 2014_163109_0031, Resident Quality Inspection - VPC was issued.
- 2016_382596_0004, Resident Quality Inspection - Compliance Order was issued

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

The licensee has failed to ensure that the person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director.

The home submitted CIS report to the MOHLTC on an identified date in 2016, alleging staff to resident abuse for resident #012. The CIS reported the resident's family member reported two days prior that he/she observed multiple areas of altered skin integrity on resident #012's identified body areas.

Review of resident #012's care records revealed a progress note documented by RN #186 on an identified time and date in 2016, identifying resident #012's family member had voiced his/her concerns to RPN #167 related to the identified skin integrity alterations observed on resident #012, alleging abuse of the resident by staff. The progress note indicated RPN #167 had subsequently reported the allegation to RN #186. The progress note further identified a voice message was left for the on call manager. No further documentation was identified related to this incident for the identified date.

Interview with RPN #167 revealed resident #012's family member had approached him/her on an identified date in 2016, during the evening shift and alleged staff had abused resident #012 due to the identified altered skin integrity observed on resident #012. RPN #167 reported the allegation to RN #186.

Interview with RN #186 revealed he/she was aware that registered staff are to report alleged, suspected, or witnessed abuse to the MOHTLC immediately upon becoming aware. RN #186 reported he/she was informed of the allegation and the on call manager was informed. RN #186 was unable to confirm that he/she informed the MOHTLC upon becoming aware of the alleged abuse.

Interview with the home's Administrator revealed registered staff were required to inform the MOHLTC of allegations of abuse in the home. Staff are then directed to communicate with the on-call manager to confirm that a report to the MOHLTC of the allegation has been made and document it in the resident's clinical records. The administrator confirmed the allegation of abuse reported to staff by resident #012's family member on the identified date in 2016, was not reported to the MOHTLC until two days later. The administrator confirmed the home did not follow immediate reporting requirements as per legislative requirements.

***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 person who had reasonable grounds to suspect abuse of a resident by anyone that resulted in harm or risk of harm immediately reported the suspicion and the information upon which it was based to the Director, to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care**

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

**s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

The MOHLTC received a complaint reporting concerns regarding resident #013's foot care.

Review of resident #013's progress note on an identified date 2016, revealed his/her family communicated their concern related to foot care to ADOC #156. Review of another progress note four days later, identified foot care was provided to resident #013 by RPN #116. The progress note stated the resident did not have a specific medical condition, characteristic of resident's nails, did not require foot care from nursing, and that PSW's could manage.

Record review of the written plan of care on an identified date, identified resident was to receive foot care after an identified personal care task by the PSW staff.

Review of the POC documentation for an identified three months in 2016, revealed that in one of the identified months, resident #013 received foot care on eight occasions. No documentation for an identified task was noted for the identified month. On the second identified month, resident #013 received foot care on nine occasions. No documentation for an identified task was noted for this month. On the third identified month, resident #013 received foot care on five occasions. No documentation for an identified task was noted for this month.

Interview with PSW #183 revealed routine grooming of residents after showers or baths included checking, cleaning, and trimming of toe nails by the PSW staff. PSW #183 reported if toe nails were checked, cleaned, and/or trimmed for a resident, documentation reflecting precisely which nail care was provided for a resident would be in POC.

Interview with PSW #161, a full time regular care provider for resident #013, revealed PSW staff were to provide residents with toe nail care including trimming after a shower or bath unless otherwise clinically indicated, such as diabetes or thickened toe nails. PSW #161 reported if thickened nails were observed on a resident, PSW's would be directed to document it in a communication book for the foot care RN. PSW #161 was unable to demonstrate whether resident #013 had thickened nails or whether he/she was precluded from receiving trimming of toe nails for any other reason. PSW #161 reported he/she routinely provided resident #013 with shower care, and did not provide toe nail trimming to resident #013 for an identified month in 2016.

Interview with RN #116 revealed residents who did not have identified medical concerns were able to receive routine toe nail care including trimming and cleaning from PSW staff. RPN #116 reported he/she was directed by ADOC #106 to trim resident #013's toe nails on an identified date in 2016. RPN #116 reported that he/she informed ADOC#106 through email communication on an identified date in 2016, that he/she trimmed resident #013's toe nails with a routine nail clipper and did not find resident #013's toe nails to preclude him/her from routine toe nail care from PSW's.

Interview with the Resident Assessment Instrument (RAI) Coordinator and ADOC #156 stated PSW staff are expected to provide toe nail trimming as part of routine nail care unless otherwise clinical contraindicated for a resident. The RAI Coordinator and ADOC reviewed the POC records for toe nail care and direct care staff responses for an identified month in 2016, and acknowledged resident #013 was not offered routine toe nail trimming as per home's expectation.

The home failed to ensure that resident #013 received basic foot care services, including the cutting of toenails.

***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 -ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection., to be implemented voluntarily.***

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents**

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

**s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):**
**1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).**
**2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,**
**i. a breakdown or failure of the security system,**
**ii. a breakdown of major equipment or a system in the home,**
**iii. a loss of essential services, or**
**iv. flooding.**
**O. Reg. 79/10, s. 107 (3).**
**3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).**
**4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).**
**5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).**

**Findings/Faits saillants :**

The licensee failed to ensure that the Director is informed subject to subsection (3.1), of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

The MOHLTC ACTIONline received a complaint on an identified date in 2016, regarding resident #001. The complainant indicated resident #001 sustained an identified injury and complained of pain. As per intake, complainant was concerned about the increase in falls the resident had and the overall care resident received.

Interview with ADOC/Fall Prevention Lead #106 indicated it is the home's expectation that a Critical Incident System report is completed if a resident sustained an identified injury as a result of a fall.

Interview with the IDOC #156 indicated resident #001 was transferred to hospital on an identified date in 2016, for futher assessment, after an unwitnessed fall on an identified date in 2016. The IDOC stated the home did not realize that the required assessments were not done in hospital, and the physician ordered an identified assessment the following month. IDOC indicated that upon the home's discovery on an identified date in 2016, that resident #001 sustained the identified injury, as a result of the fall, a Critical Incident System report should have been submitted to the MOHLTC Director. The IDOC indicated that a CIS report was not submitted to the MOHLTC upon discovery of the injury on the identified date. The IDOC stated the home's expectation of completing a CIS report was not followed as resident sustained an identified injury after his/her fall.

***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 Director is informed subject to subsection (3.1), of an incident that causes an injury to a resident for which the resident is taken to a hospital and that results in a significant change in the resident's health condition no later than one business day after the occurrence of the incident, followed by the report required under subsection (4), to be implemented voluntarily.***

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**WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**11. Every resident has the right to,**
**i. participate fully in the development, implementation, review and revision of his or her plan of care,**
**ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,**
**iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and**
**iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

The licensee failed to ensure to fully respect and promote the resident's right to give or refuse consent to any treatment, care or services for which consent is required by law.

During the inspection of an identified complaint for resident #014, the SDM was interviewed and reported that the home did not report to him/her when medications were changed for resident #014.

Review of resident #014's documented clinical records identified a medication change was made on an identified date in 2016 for an identified number of resident #014's medications, by an identified external consult team.
Interview with RPN #147 and RN#126 revealed the home's staff were expected to contact a resident's SDM to inform them and obtain consent for resident related medication changes. RPN# 147 stated communications for obtained consent from an SDM were expected to be documented in the resident's clinical records. Review of resident #014's clinical records with RPN #147 could not locate if consent was obtained and documented for the medication change noted on the identified date in 2016.

Interview and review of resident #014's clinical records with ADOC #156 acknowledged that the home could not demonstrate that consent had been obtained for medication changes noted above.

The licensee failed to ensure consent for changes in medication for resident #014 was obtained as required by law.

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**WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care**

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

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

**s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**Findings/Faits saillants :**

The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other.

The MOHLTC ACTIONline received a complaint on an identified date in 2016, regarding resident #001. The complainant indicated resident #001 sustained an identified injury and complained of pain. As per intake, complainant was concerned about the increase in falls the resident had and the overall care resident received.

On an identified date in 2016, resident #001 had an unwitnessed fall and diagnosed with an identified injury.

Record review of resident's electronic progress notes revealed he/she started to complain of an identified pain after the fall, and was prescribed pain medication.

Review of resident #001's, clinical records found a report from an identified external consult team on an identified date recommending two specific pain management recommendations.

Review of resident #001's clinical records both electronic and paper did not locate documentation that the registered staff reviewed and assessed the identified consult teams's recommendations for resident #001's pain management. Further review of resident #001's plan of care during a three month period in 2016, the plan of care did not

include any of the recommendations from the identified consult team.

Interviews with RNs #125 and #137 indicated it is the home's expectation for recommendations from the identified consult team be addressed by the registered staff in the unit and the plan of care be updated if the recommendations are to be implemented. RNs #125 and #137 acknowledged the registered staff did not address and assess the recommendations from the external consult team as per home's expectation.

Interview with the SPRN #149 indicated it is the home's expectation for recommendations from external consultants be addressed by the unit staff and the plan of care is to be updated if any of the recommendations are to be implemented. SPRN #149 reviewed resident #001's clinical records and did not locate documentation that the recommendations were addressed by the home staff. SPRN #149 acknowledged the recommendations from the identified external consult team was not addressed and the home did not collaborate with each other in the assessment of resident #001 so that their assessments are integrated and are consistent with and complement each other.

Interview with IDOC #156 indicated it is the home's expectation for the plan and recommendations from the identified external consult team is to be addressed by the registered staff and reviewed by the physician. The plan of care is to be updated to reflect interventions that are to be implemented. IDOC #156 reviewed the plan of care of resident #001 and acknowledged the plan and recommendations from the identified consult team was not addressed and reviewed by the home. IDOC #156 acknowledged the home did not collaborate in the assessment of resident #001's pain management.

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service**

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

**s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,**
**(a) procedures are developed and implemented to ensure that,**
**(i) residents' linens are changed at least once a week and more often as needed,**
**(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,**
**(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and**
**(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).**

**Findings/Faits saillants :**

The licensee has failed to ensure that procedures are developed and implemented to ensure that there is a process to report and locate residents' lost clothing and personal items.

The MOHLTC received a complaint via the Action Line on an identified date in 2017. The complainant indicated that resident #002 lost an identified personal item.

A review of resident #002's electronic progress notes revealed on an identified date in 2016, a PSW reported to RPN #120, that the identified personal item belonging to resident was missing.

Interviews with RPNs #104, #109, #122, and #148 and RNs #105 and #118 indicated when a resident's clothing and or personal item is missing, the registered staff initiates the "Report of Lost or Missing Articles" form. A search is initiated by the unit staff and the form is posted in the nursing station for staff to continue to search for the item. The "Report of Lost or Missing Articles" form is filed in the resident's chart once the item is found or when the search has been completed. The staff above indicated a CSR form is not initiated.

Review of resident #002's physical chart did not locate a completed "Report of Lost or Missing Articles" form.

Interviews with ADOCs #106 and #156 indicated the process for lost clothing and

personal items is for a "Report of Lost or Missing Articles" form is initiated by the unit nurse. The ADOCs stated a CSR is not completed for residents' missing clothing or personal items. ADOC #106 stated the completed "Report of Lost or Missing Articles" form is filed in the resident's chart once the item is found or when the search has been completed.

Interview with the Environmental Services Manager (ESM) #181 indicated when residents have missing clothing or personal items, a CSR form is initiated. The ESM stated he does receive the "Report of Lost or Missing Articles" form from the nursing department at times.

Interview with the Quality Coordinator (QC) #108 stated the home is to follow the home's CSR policy when residents have missing clothing or personal items.

Review of the home's CSR/Complaints Binder did not locate a CSR for resident #002's missing personal item.

Interview with the home's Administrator #124 indicated when a resident's clothing or personal item is missing, it is the home's expectation that a CSR form is completed. The Administrator stated the home did not follow the home's expectation since a CSR form was not completed for resident #002's missing personal item.

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**WN #10: 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).**

## Findings/Faits saillants :

The licensee has failed to ensure that every verbal complaint made to the licensee or a staff member concerning the care of a resident shall be investigated and resolved where possible, and response that complies with paragraph 3 provided within 10 business days of the receipts of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.

The MOHLTC, ACTIONline received a complainant on an identified date in 2017, from resident #021's SDM who stated that the resident was transferred to hospital on an identified date in 2017, due to a an identified area of altered skin integrity which staff were unaware of.

An interview with resident #021's SDM indicated the resident had been transferred to hospital on an identified date in 2017, as the SWL identified an area of altered skin integrity on the side of resident #021's identified body area. The SDM stated the resident was seen in hospital and was informed there was nothing they could do for the identified area of altered skin integrity and the resident returned to the LTCH. The SDM questioned as to how the staff did not see the site during care and indicated he/she spoke with the DOC of his/her concerns.

The home's policy "Quality Improvement", "Client Services Response From", under procedure number one stated that it is the responsibility of the person receiving a complaint/concern to document the information on a "Client Service Response Form". All section on the form are too completed. The completed form will be forwarded to the Social Services Coordinator within 72hrs.

The inspector spoke to the home and requested Client Services Response (CSR) forms completed for an identified month in 2017. Review of the CSRs for the identified month, revealed there was no record of a CSR form completed for resident #002's SDM concerns.

Interview with the DOC indicated once a complaint is brought to an individual according to the home's policy, a CSR form is to be completed and an investigation is to be started. The DOC indicated he/she was informed by resident #012's SDM of his/her concern related to the resident developing an area of altered skin integrity and requested resident #021's chart. The DOC indicated a CSR form was not completed by him/herself for the concern and an investigation was not started and the home's policy was not followed.

**Issued on this 27th day of September, 2017**

[redacted]

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

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

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

## Public Copy/Copie du public

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|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JOY IERACI (665), JENNIFER BROWN (647), JOVAIRIA AWAN (648), SARAH KENNEDY (605) |
| **Inspection No. / No de l'inspection :** | 2017_527665_0004 |
| **Log No. / No de registre :** | 017896-16, 019423-16, 026264-16, 031978-16, 034624-16, 034863-16, 035373-16, 000242-17, 000954-17, 004149-17, 005112-17, 006676-17, 007825-17 |
| **Type of Inspection / Genre d'inspection:** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Sep 11, 2017 |
| **Licensee / Titulaire de permis :** | RYKKA CARE CENTRES LP<br>3200 Dufferin Street, Suite 407, TORONTO, ON, M6A-3B2 |
| **LTC Home / Foyer de SLD :** | HAWTHORNE PLACE CARE CENTRE<br>2045 FINCH AVENUE WEST, NORTH YORK, ON, M3N-1M9 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Linda Joseph-Massiah |

To RYKKA CARE CENTRES 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) (b)

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee shall prepare, submit, and implement a plan that ensures that the following policies and procedures are in compliance with, and are implemented in accordance with all applicable requirements under the Act, related to:

1. The home's Skin Care and Wound Management Program manual for Responsive Health Management (revised April 2010).

a) The PSW staff shall report an identified altered skin integrity to the unit supervisor, document skin integrity every shift, and ensure that there is documented evidence that the PSW promotes skin integrity.

b) The RN/RPN Unit Supervisor shall notify the Skin Care coordinator and Registered Dietitian when there is an identified areas of altered skin integrity present, the SDM and physician.

c) Members of the interdisciplinary team shall receive referrals from the registered staff and/or physician and assesses all residents with areas of skin integrity.

2. The home's Falls Prevention Program with a revised date of March 2014, under Post Fall Assessment policy.

The applicable staff shall notify the physician immediately and provide him/her with the assessment, vital signs and the clinical symptoms of the evidence of the injury, and also notify the substitute decision maker (family).

The plan must be submitted by September 21, 2017, to joy.ieraci@ontario.ca.

**Grounds / Motifs :**

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

O. Reg.79/10, s. 30 (1) (1), Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral

of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1) (1).

1. The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long Term Care (MOHLTC) on an identified date in2016, alleging staff to resident abuse for resident #012. The CIS report indicated the resident's family member reported that he/she observed multiple areas of altered skin integrity on identified body areas on resident #012. The family member also submitted complaints regarding the same matter on identified dates in 2016, through the MOHLTC ActionLine.

Interview with the complainant identified that he/she reported that on the date of the alleged abuse, he/she noticed areas of altered skin integrity on two areas of resident #012's body. The complainant stated he/she had noticed the altered skin integrity on previous visits. The complaint acknowledged medication was known to cause altered skin integrity, however was not satisfied with the home's response related to this particular incident.

Record review of the home's Skin Care and Wound Management Program manual for Responsive Health Management (Revised April 2010) indicated Personal Support Workers (PSW) were to report the identified areas of altered skin integrity to the unit supervisor, document skin integrity every shift, and ensure that there is documented evidence that the PSW promotes skin integrity.

Review of resident #012's clinical records identified the home initiated a treatment administration record (TAR) five days after the identified altered skin integrity were noted. The TAR directed staff to monitor resident's skin daily for the identified areas of altered skin integrity and document in Point Click Care (PCC) under skin and wound.

Interviews with PSW #100 revealed that PSW staff were to monitor resident's skin every morning and report new skin changes including the areas of altered skin integrity to registered staff. PSW #100 reported he/she was aware of resident #012's ongoing identified altered skin integrity but was unable to confirm if he/she had reported it to registered staff.

Interview with PSW #189 revealed he/she was assigned to resident #012 on an identified date in 2016. PSW #189 reported he/she had observed the identified areas of altered skin integrity on resident #012's identified body area but had not

reported it to the registered staff.

PSW #100 and PSW #189 revealed resident #012 was known for having identified responsive behaviours and suggested this as a contributing factor to the ongoing identified areas of altered skin integrity.

Interview with Registered Practical Nurse (RPN) #167 revealed the home's expectation is for PSW staff to report the identified altered skin integrity on resident's skin to registered staff.

Interview with the Skin and Wound Lead (SWL) #116 revealed PSW staff are expected to report the identified areas of altered skin integrity or changes in skin to registered staff on an ongoing basis. Review of resident #012's written plan of care with Registered Nurse (RN) #116 revealed it did not clearly identify residents' history of the ongoing identified altered skin integrity, contributing medical conditions, or contributing responsive behaviors despite direct care staff reporting otherwise. RN #116 confirmed PSW staff did not meet the home's expectation for monitoring skin changes as resident #012's known history of the identified altered skin integrity was not captured in the plan of care, and documented and assessed as per the home's Skin Care and Wound Management Program.

Interview with Associate Director of Care (ADOC) #156 revealed direct care staff are directed to immediately report changes in skin condition including the altered skin integrity alteration to registered staff. Record review of resident #012's progress notes with ADOC #156 identified that the ongoing altered skin integrity on resident #012's was not documented for 2016, prior to the date of the alleged abuse.

2. The MOHLTC, ACTIONline received a complaint on an identified date in 2017, from resident #021's Substitute Decision Maker (SDM). The SDM indicated resident #021 developed an identified area of altered skin integrity during a particular month in 2016, and had not been notified. The resident was transferred to hospital on an identified date in 2017, and the hospital informed the SDM of the identified altered skin integrity and another area of altered skin integrity.

A review of resident #021's PCC progress note on an identified date in 2016, indicated resident had an identified area of altered skin integrity that had

deteriorated, the PCC note had no description of the identified altered skin integrity and the physician ordered an identified intervention to promote healing.

A review of the home's policy "Skin Care & Wound Management" program, "The Role of the Unit supervision (RN/RPN), under procedure number seven, directed the staff to notify the Skin Care coordinator and Registered Dietitian when there is skin breakdown present, the SDM and physician.

Interview with RPN #142 indicated when there is an area of altered skin integrity identified for a resident, a skin and wound care referral is to be sent to the home's SWL in order to have the resident's skin be assessed. The RPN confirmed he/she documented a progress note on an identified date in 2016, when he/she found the area of altered skin integrity on resident #021's identified body area. The RPN reviewed the progress notes for resident #021 and indicated he/she did not send a skin and wound care referral to the SWL when the resident's identified area of altered skin integrity had deteriorated as per the home's policy and procedures.

Interviews carried out with the home's SWL #116 and the Interim Director of Care (IDOC) #156 indicated it was the home's policy for a referral to be sent to the home's SWL in order for the skin issue to be assessed. The SWL and IDOC reviewed resident #021's progress notes and confirmed when resident #021's identified area of altered skin integrity had deteriorated, a referral was not sent to the SWL as per the home's policy. [s. 8. (1)]

3. The MOHLTC, ACTIONline received a call on an identified date in 2017, from resident #021's SDM. The SDM indicated resident #021 developed an identified area of altered skin integrity on an identified date in 2016, and had not been notified of the area of altered skin integrity . The resident was transferred to hospital on an identified date in 2017, and the hospital informed the SDM of two areas of identified altered skin integrity.

Interviews conducted with resident #021's SDM #113 indicated the home did not inform him/her of the resident having an identified area of skin integrity on an identified body area. The SDM stated he/she was unaware of the identified area of altered skin integrity to the identified body area.

A review of the home's policy "Skin Care & Wound Management" program, "The Role of the Unit supervision (RN/RPN), under procedure number seven directed

the staff to notify the Skin Care coordinator and Registered Dietitian when there is skin breakdown present, the SDM and physician.

A review of resident #021's PCC progress note on an identified date in 2016, indicated resident had an identified area of altered skin integrity on an identified body area and the PCC note did not identify the assessed condition of the area of altered skin integrity and the physician ordered an identified intervention to promote healing.

Interview with RPN #142 indicated it is the home's policy to contact the SDM when there is skin breakdown. The RPN confirmed he/she documented a progress note on an identified date in 2016, as he/she found an an area of altered skin integrity on resident #021's. RPN #142 was not able to recall if the SDM had been notified of the identified area of altered skin integrity as per the home's policy and procedures.

Interviews carried out with the home's SWL #116 and the IDOC #156 indicated it was the home's policy for the family be called at the time when altered skin integrity was identified to ensure the family was aware of the health status of the resident. The SWL and IDOC confirmed after they reviewed the progress notes of resident #021 on PCC and they did not find evidence of the SDM being informed on an identified month regarding the identified area of altered skin integrity. The SWL and the IDOC stated the home's policy to inform the SDM's when altered skin integrity was identified was not followed.

4. On March 3, 2017, MOHLTC ACTIONline received a complaint involving resident #022. The complainant stated resident #022 was transferred to hospital as there was a change in his/her health status. The complainant indicated he/she was notified by the hospital that resident #022 had an identified area of altered skin integrity and questioned as to why the identified area of altered skin integrity was not treated. The POA indicated he/she met with the home's administrator who indicated the resident would be cared for.

A review of the PCC progress notes revealed a note on an identified date in 2016, stated resident #022's identified area of altered skin integrity had deteriorated , treatment applied and it would be endorsed to all shifts to continue with treatment.

A review of the Pixler skin assessment program, the skin assessment carried out

on an identified date in 2016, identified resident #022's identified area of altered skin integrity.

Interviews conducted with resident #022's SDMs #135 and #136 indicated the home did not inform them of the resident having the identified area of altered skin integrity. SDM #135 indicated the home should have informed him/her of the resident's declining area of altered skin integrity.

A review of the home's policy "Skin Care & Wound Management" program, "The Role of the Unit supervision (RN/RPN), under procedure number seven directs the staff to notify the Skin Care coordinator and Registered Dietitian when there is skin breakdown present, the SDM and physician.

Interview with RPN #104 confirmed he/she documented a progress note on an identified date in 2016, when he/she found the identified area of altered skin integrity on resident #022's body and did not recall calling the family of resident #022 to inform them of the area of altered skin integrity as per the home's policy and procedures.

Interviews carried out with the home's SWL #116 and the IDOC #156 indicated it was the home's policy the family be called at the time when an area of altered skin integrity was identified to ensure the family was aware of the health status of the resident. The SWL and IDOC confirmed after they reviewed the progress notes of resident #022 on PCC that they did not find evidence of the SDM being informed in an identified month after the identified area of altered skin integrity was identified and acknowledged the staff did not identify a specific characteristic of the identified area of altered skin integrity. The SWL and the IDOC stated the home's policy to inform the SDM when an area of altered skin integrity was identified was not followed.

5. The MOHLTC ACTIONline received a complaint on an identified date in 2016, by a complainant from a hospital who was caring for resident #023. The complainant indicated he/she had concerns that the home may not have provided identified skin care for resident #023 as the resident had an identified number of areas of altered skin integrity. The complainant stated resident was under treatment for an identified condition, and alleged that the home did not provide appropriate skin treatments.

A review of the home's "Skin Care & Wound Management Program", Quality

Management the role of other members of the interdisciplinary team directs staff under procedure number five: Receives referrals from the registered staff and/or physician and assesses all residents with identified areas of altered skin integrity.

A review of resident #023's admission notes on PCC indicated the resident was admitted to the home in 2016, with an identified number of areas of altered skin integrity to identified body areas, no other information had been documented related to the identified areas of altered skin integrity.

Interviews with RN #118 and the SWL stated that once a resident is identified with areas of altered skin integrity , a skin and wound referral is to be sent to the home's SWL through PCC as soon as possible. The RN reviewed resident #023's PCC notes and indicated that on admission, resident #023, was identified as having an identified number of ares of altered skin integrity and he/she was unable to locate a skin and wound referral being sent to the home's SWL.

Interview with the Director of Care (DOC) stated registered staff are expected to send skin and wound referrals to the home's SWL once a resident is identified to areas of altered skin integrity. The DOC conducted a review of resident #023's PCC notes and indicated that a referral for resident #023's identified areas of altered skin integrity was not sent as per home's policy. [s. 8. (1)]

6. The MOHLTC ACTIONline received a complaint on an identified date in 2016, regarding resident #001. The complainant indicated resident #001 sustained an identified injury to resident #001's body and complained of pain. As per intake, complainant was concerned about the increase in falls the resident had and the overall care resident received.

O. Reg.79/10, s. 30 (1) (1), Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation: There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1) (1).

A review of the home's Falls Prevention Program with a Revised date of March 2014, indicated, under the Post Fall Assessment Policy, number five of the procedure, "Notify the physician immediately and provide him/her with the assessment, vital signs and the clinical symptoms of the evidence of the injury, and also notify the substitute decision maker (family)."

On an identified date in 2016, resident #001 had an unwitnessed fall. Record review of resident #001's progress notes revealed the outgoing registered staff endorsed to the incoming registered staff to notify the SDM of resident #001's fall incident. Further review of the progress notes found the SDM was notified of the fall two days after the incident, when resident #001 was transferred to hospital as a result of the fall.

Interview with RN #125 indicated it is the home's expectation for a SDM to be notified immediately when a resident has a fall. RN #125 acknowledged that he/she was to notify resident #001's SDM on the day of the fall, after the identified nurse endorsed the task to him/her. RN #125 stated he/she did not follow the home's expectation of notifying resident #001's SDM regarding the fall.

Interview with the ADOC/Fall Prevention Lead #106 indicated it is the home's expectation for a resident's SDM be notified within the same day when a resident has a fall. ADOC #106 reviewed the clinical record of resident #001 and acknowledged resident #001's SDM was not notified until two days later, when resident was being transferred to hospital as a result of the fall. ADOC #106 indicated the staff did not follow home's policy regarding notification of resident #001's fall to his/her SDM.

Interview with the IDOC #156 indicated as part of the home's falls program, the SDMs are to be notified as soon as possible when a resident has a fall. IDOC #156 reviewed the clinical records of resident #001 and acknowledged resident's SDM was not notified until two days later, when resident was being transferred to hospital as a result of the fall. IDOC #156 stated the staff did not follow the home's falls program regarding notifying the SDM of resident #001.

The home is being served an order as the home did not comply with their policies and procedures on Skin and Wound for four identified residents and Falls Prevention for one identified resident.  Resident #012 had identified ares of altered skin integrity which was not reported to the registered staff by the PSWs

and the staff did not document skin integrity for the resident as per home's policy. Resident #021's identified area of altered skin integrity had deteriorated and the home did not send a referral to the SWL and the SDM was not notified of the skin breakdown as per home's policy. Resident #022 had an area of altered skin integrity that had deteriorated as per progress note on an identified date in 2016, the SDM was not notified of the area of altered skin integrity as per home's policy. Resident #023 was admitted to the home on in 2016, with an identified number of areas of altered skin integrity. A skin and wound referral was not sent to the SWL to assess the areas of altered skin integrity as per the home's policy. Resident #001 had an unwitnessed fall, and the SDM was not notified until the resident was transferred to hospital two days after, for further assessment as a result of the fall.

The severity of the non-compliance and the severity of harm and risk was potential for actual harm as:

- Resident #012's identified areas of altered skin integrity were not reported to the registered staff and skin integrity documentation was not completed
- SDMs of residents' #021 and #022 were not notified of the residents' areas of altered skin integrity
- Referrals to the home's SWL were not sent for residents #021 and #023
- SDM of resident #001 was not notified of a the resident's fall until the day the resident was transferred to hospital, two days later

The scope of the non-compliance was a pattern.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, O. Reg. 79/10, s. 8. (1), was issued. The Non-compliances are as follows:

- 2016_382596_0004, Resident Quality Inspection - VPC was issued.
- 2015_268604_0011, Resident Quality Inspection - VPC was issued.

(665)

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 21, 2017

**Order # / Ordre no :** 002

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

**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 :**

The licensee shall prepare, submit and implement a plan to ensure that registered staff are aware of their responsibilities related to skin and wound care:

1. A resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff within 24 hours of the resident's admission

2. A resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff upon any return of the resident from hospital.

3. A resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

4. A resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receives a skin assessment by a member of the registered nursing staff, receives immediate treatment and interventions to promote healing.

The plan shall include but is not limited to the following areas:

1) Educate all registered staff on when a skin assessment is required, including but not limited to, within 24 hours of admission of a resident at risk of altered skin integrity and upon return from hospital; and who is responsible for the assessment.

2) Education should include a review of all applicable assessment tools, including the home's Pixler Skin Assessment tool, as well as specify what type of information is to be documented and where, as it relates to altered skin integrity assessments.

3) The plan shall indicate who is responsible for the education and when the education will be conducted. The home shall keep record of names of staff who attends the education, the date of the education, and the content and materials reviewed at the time of the education.

4) The development of a system to ensure residents receive a skin assessment, when required, and residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive immediate treatment to promote healing.

The plan shall be submitted by September 21, 2017, to joy.ieraci@ontario.ca.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the resident received a skin assessment by a member of the registered nursing staff within 24 hours of admission.

1. The MOHLTC ACTIONline received a complaint on an identified date in 2016, by a complainant who was caring for resident #023 at the hospital. The complainant indicated he/she had concerns of inadequate skin care for resident #023 as the resident had an identified number of areas of altered skin integrity to identified body areas. The complainant stated the resident was under treatment for an identified medical condition, and alleged that the home did not provide skin care treatments.

A review of resident #023's admission notes on PCC indicated the resident was admitted to the home on an identified date in 2016, with identified areas of altered skin integrity with no other information provided related to the areas of altered skin integrity characteristics.

Interview with RN #118 stated it was the home's expectation that a skin assessment was to be completed on Pixler the homes skin assessment tool immediately when a resident is admitted with areas of altered skin integrity. The RN reviewed resident #023's PCC notes and confirmed he/she carried out the admission for resident #023. The RN reviewed Pixler and indicated a skin assessment was not carried out within 24 hrs of admission for resident #023 and a skin assessment was only carried out seven days later by the home's SWL.

Interview with the home's SWL #116 stated when a resident is admitted to the home with the identified areas of altered skin integrity, the registered staff is to carry out a skin assessment on Pixler which will create a skin and wound profile for the newly admitted resident and then inform him/her of the identified areas of altered skin integrity. The SWL indicated that a review of the admission note stated resident #023 had the identified number of areas of altered skin integrity with no other characteristics of the areas of altered skin integrity documented. A review of Pixler showed that a skin assessment on the identified areas of altered skin integrity for resident #023 had been conducted on an identified date, seven days after the resident's admission date by the SWL.

Interview with the home's IDOC indicated it is the home's expectation that a skin assessment be completed on Pixler immediately when a resident is admitted with areas of altered skin integrity. The IDOC reviewed resident #023's PCC notes and Pixler and stated that resident #023 was admitted with the identified areas of altered skin integrity and a skin assessment had not been completed within 24 hours of admission as required.

2. The licensee had failed to ensure that the resident exhibiting altered skin integrity received a skin assessment by a member of the registered staff upon return from hospital.

The MOHLTC, ACTIONline received a complaint on an identified date in 2017, from resident #021's SDM. The SDM indicated resident #021 developed an identified area of altered skin integrity on an identified month in 2016, and he/she had not been notified of the altered skin integrity. The resident was transferred to hospital on an identified date in 2017, and the hospital informed the SDM of the identified altered skin integrity.

A review of resident #021's PCC progress notes indicated that on an identified date in 2017, the resident was transferred to hospital due to a significant change to resident's identified altered skin integrity, discovery of a new altered skin integrity on an identified number of sites on resident #021's body. Further review of the progress notes indicated the resident was readmitted to the home on an identified date in 2017 and diagnosed with an identified medical concern. The note indicated resident #021 had an identified altered skin integrity with no description of the site.

A review of resident #021's documentation did not reveal that a skin assessment had been completed by registered staff when the resident was readmitted to the home from hospital on the identified date in 2017. A skin assessment on the Pixler program was documented on an identified date in 2017, which identified the altered skin integrity's type, nine days later.

Interviews conducted with the SLW #116 and IDOC #156, indicated it was the home's expectation a head to toe assessment be carried out on readmission from hospital and a Pixler skin assessment be completed when the identified area of altered skin integrity is identified. The SLW and IDOC reviewed PCC and the Pixler program and indicated a skin assessment had not been completed for

resident #021 on readmission from hospital and a skin assessment was only carried out nine days later which revealed the identified the altered skin integrity's type.

3. The licensee has 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 MOHLTC ACTIONline received a complaint related to resident #022 on an identified date in 2017. The complainant stated resident #022 was transferred to hospital as there was a change in his/her health status. The complainant was notified that the resident had an identified area of altered skin integrity and was questioned by the hospital as to why the identified area of altered skin integrity was not treated. The POC indicated he/she met with the home's administrator who indicated the resident would be cared for.

A review of the PCC progress notes revealed a note on an identified date in 2016, which stated resident #022's identified area of altered skin integrity had deteriorated, treatment provided and it would be endorsed to all shift to continue with treatment. The progress note did not give any characteristics of the identified area of altered skin integrity.

In another progress note on an identified date in 2017, resident #022 was transferred to an identified hospital. On an identified date in 2017, readmission from hospital progress notes created by RPN #140 did not give characteristics of the identified skin breakdown. Further review of the progress notes revealed a progress note six days later indicating, a skin assessment for resident #022 was completed and found to have an identified area of altered skin integrity with characteristics identified.

Interview with RPN #104 confirmed the home utilized the Pixler program to document skin assessments on areas of altered skin integrity. The RPN stated he/she documented the progress note on an identified date in 2016, when he/she found the identified area of altered skin integrity on resident #022 and did not document characteristics of the site. The RPN indicated he/she did not document a skin assessment on Pixler program for resident #022's identified area of altered skin integrity.

Interviews carried out with the home's SWL #116 and the home's IDOC #156 indicated the tool the home utilizes for documenting skin assessments was the Pixler program. The SWL and IDOC indicated it was an expectation when a resident is readmitted from hospital and when an the identified area of altered skin integrity is identified on readmission from hospital, a skin assessment is to be carried out on the Pixler program. They indicated the Pixler program is to be used when a skin conditions such as areas of altered skin integrity is identified on a resident. The SWL and the IDOC indicated that on the identified date in 2016, resident #022 was identified with an area of altered skin integrity. The SWL stated he/she carried out a skin assessment on Pixler on an identified date in 2016, seven days later and found the identified area of altered skin integrity with an identified characteristic. The SWL and the IDOC stated the resident's identified area of altered skin integrity would show a change of condition and when this change was identified by the RPN, the RPN should have used Pixler program to create a profile and a skin assessment for resident #022 should have been done on the home's skin assessment tool Pixler, which was not done. After the SWL and IDOC reviewed the progress notes the SWL and the IDOC confirmed that upon readmission from hospital of resident #022, he/she did not receive a skin assessment when he/she was identified as having the identified altered skin integrity as per the progress note and a skin assessment was carried out six days later on an identified date in 2017 in the Pixler program.

4. The licensee of a long-term care home shall ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receive immediate treatment to promote healing.

The MOHLTC ACTIONline received a complaint on an identified date in 2016, by a complainant from a hospital who was caring for resident #023. The complainant indicated he/she had concerns that the home may not have provided identified skin care for resident #023 as the resident had an identified number of areas of altered skin integrity.

A review of resident #023's admission notes on Point Click Care (PCC) indicated the resident was admitted to the home on an identified date in 2016 with an identified number of areas of altered skin integrity and no other information was provided related to identified areas of altered skin integrity characteristics.

A review of resident #023's Medication Administration Records (MARS) and Treatments Administration Records (TARS) for an identified month in 2016, revealed a physician order for the identified areas of altered skin integrity with an identified start date. There were "X"s for an identified period of days in the identified month indicating no treatment being carried out. A review of resident #023's PCC notes, did not show any evidence of any treatment being carried out for resident #023's identified areas of altered skin integrity for the identified period of days.

Interviews with RN #118 and the home's SWL confirmed resident #023 was admitted to the home on with identified number of areas of altered skin integrity to his/her body and a review of the MARS and TARS indicated that there was no care or treatment being provided to the identified areas of altered skin integrity from the identified period of days. RN #118 stated an "X" means that no care or treatment was provided and care for the identified areas of altered skin integrity was only started on an identified date in 2016. The SWL stated that he/she was unable to find a treatment order for the identified areas of altered skin integrity for resident #023.

Interview with IDOC #156, stated resident #023 was admitted to the home with identified number of areas of altered skin integrity. The IDOC reviewed resident #023's MARS and TARS for an identified month in 2016, PCC notes from the identified period of days in 2016, and skin assessments carried out on Pixler and acknowledged he/she was unable to find evidence to show that the home provided any care or treatment to the resident's identified number of areas of altered skin integrity since admission. The IDOC acknowledged that the SWL only assessed the identified number of areas of altered skin integrity seven days later when the identified areas of altered skin integrity were at an identified characteristic and then put a treatment plan in place to care for the identified areas of altered skin integrity for resident #023's identified areas of altered skin integrity.

The severity of the non-compliance and the severity of harm and risk was actual.

-On an identified date in 2016, resident #023 was admitted to the home with identified number of areas of altered skin integrity, there was no evidence to show that the home carried out a skin assessment or treatments on the resident's areas of altered skin integrity until seven days later, when the identified areas of altered skin integrity were at an identified chararcteristic.

-On an identified date in 2017, resident #021 was transferred to hospital due to a significant change to resident's identified altered skin integrity, discovery of a new altered skin integrity on an identified number of sites on resident #021's body. The resident was readmitted to the home on an identified date in 2017 and diagnosed with an identified medical condition. The note indicated resident #021 had an identified altered skin integrity with no description of the site. A skin assessment was documented nine days later, which identified the characteristic of the identified altered skin integrity.

-On an identified date in 2017, resident #022 was transferred to an identified hospital. A readmission from hospital progress notes created by RPN #140 did not give characteristics of the identified area of altered skin integrity. Further review of the progress notes revealed a progress note six days later indicating, a skin assessment for resident #022 was completed and found to have an identified area of altered skin integrity with characteristics identified.

- A progress note on an identified date, stated resident #022's identified area of altered skin integrity had reopened and the progress note did not give any characteristics of the identified area of altered skin integrity. On an identified date in 2016, seven days later, the skin assessment of the identified area of altered skin integrity was found to be at an identified characteristic.

The scope of the non-compliance was a pattern.

A review of the home's compliance history revealed no previous non-compliance related to the Long-Term Care Homes Act, Or.Reg c.8, s. 50. (2) (a) (i), (ii), and s. 50. (2) (b) (i), which was issued. [s. 50. (2) (b) (i)]
(665)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 21, 2017

**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

**Order / Ordre :**

The licensee shall prepare, submit, and implement a plan to minimize the risk of altercations and potentially harmful interactions between and among residents, including resident #014, and other residents who display an identified responsive behaviours on an identified resident home area.

The plan shall include:

1. A process to identify factors that could potentially trigger identified interactions for residents with known responsive behaviours on the identified resident home area.

2. Identifying interventions the home will implement to minimize the risk of the identified interactions on the identified resident home area between and among residents with responsive behaviours.

3. How the interventions will be implemented on the identified resident home area.

The plan must be submitted by September 21, 2017, to joy.ieraci@ontario.ca.

**Grounds / Motifs :**

1. The licensee has failed to ensure that steps are taken to minimize the risk of

altercations and potentially harmful interactions between and among residents and in identifying and implementing interventions.

The home submitted CIS report on an identified date in 2016 through the after-hours pager indicating resident #014 exhibited an identified responsive behaviour toward resident #013 on their home area. Resident #013 was subsequently sent to hospital following assessment and returned to the home on an identified date in 2016 with a diagnoses and treatment of an identified injury.

Record review of resident #014's written plan of care on an identified date, identified he/she had identified responsive behaviours toward co-residents. Interventions reviewed in the written plan of care did not identify direction to staff to minimize risk of altercation of resident #014 with co-residents on the identified resident home area. Further review of resident #014's clinical records identified six documented incidents of the identified responsive behaviour with co-residents over a six month period in 2016 on the identified resident home area.

Interview with PSW's #183, #161, and #168 revealed resident #014 was known to staff for identified responsive behaviours directed to co-residents on the identified resident home area, and identified he/she was a safety risk to other residents on the unit due to a history of identified interactions with co-residents. PSW's #183, #161, and #168 did not identify interventions available to staff to minimize the risk of altercations between resident #014 and co-residents in the identified resident home area.

Interview with PTA #153 identified resident #014 was known to staff to exhibit an identified responsive behaviour. PTA#153 identified the co-resident involved in the identified interaction with resident #014 on an identified date in 2016, sustained a fall following the identified interaction. PTA #153 reported he/she responded to the identified interaction between resident #014 and #013 on an identified date in 2016. PTA #153 reported he/she saw resident #014 standing by resident #013 in an identified area of the resident home area's hallway. PTA #153 reported resident #013 stated resident #014 had interacted with him/her.

RN #147 was identified to be on duty on the identified date in 2016, at that time of the reported incident in the identified resident home area. Interview with RN #147 revealed he/she did not witness the identified interaction between resident #014 and #013. RN #147 revealed resident #014 was known to have the identified responsive behaviour and a known history of identified altercations

with co-residents on the identified resident home area. RN #147 stated that resident #014 remained a safety risk to co-residents on the identified resident home area. RN #147 did not identify interventions available to staff to minimize the risk of the identified interactions between resident #014 and co-residents in the resident home area.

Interview with the behavioural support RPN #159 revealed resident #014 was known to him/her to have an identified responsive behaviour and had a known history of identified interactions with co-residents on the identified resident home area. RPN #159 identified resident #014 was a safety risk to co-residents on the unit due to the known history reviewed above. RPN #159 did not identify interventions available to staff to minimize the risk of the identified interactions between resident #014 and co-residents in the resident home area.

Interview with RN #118 and ADOC #156 revealed their awareness of resident #014's responsive behaviours towards co-residents. RN #118 indicated that resident #014 was a safety risk to co-residents on the unit. RN #118 and ADOC #156 did not identify interventions available to staff to minimize the risk of the identified interactions between resident #014 and co-residents in the identified resident home area. ADOC #156 further revealed no other staff were in an identified area of the resident home area to monitor residents at the time of the incident on an identified date in 2016.

Interview with the ED acknowledged the home had not considered appropriate interventions and steps to mitigate the risk of resident #014's identified responsive behaviours to co- residents on the identified resident home area.

Interviews with ADOC #156 and ED were unable to demonstrate that the home had ensured that steps were taken to minimize the risk of altercations and potentially harmful interactions between resident #014 and co-residents in the identified resident home area by identifying and implementing interventions.

The home is being served an order as the home had not identified and implemented interventions and steps to mitigate the risk of resident #014's identified responsive behaviours to co-residents on the identified resident home area. Resident #014 had known responsive behaviours and identified interactions towards co-residents on the identified resident home area. Staff interviewed indicated resident #014 was a safety risk to other residents in the unit due to his/her responsive behaviours. Documentation in the home's clinical

records for resident #014 indicated incidences when there were identified interactions with co-residents on the identified resident home area.

The severity of the non-compliance and the severity of harm and risk was actual as resident #014 had six documented responsive behaviour altercations with co-residents over a six month period in 2016.

The scope of the non-compliance was isolated.

A review of the home's compliance history revealed previous non-compliance related to the Long-Term Care Homes Act, O. Reg. 79/10, s. 54 (b), was issued. The Non-compliance are as follows:

- 2014_163109_0031, Resident Quality Inspection - VPC was issued.
- 2016_382596_0004, Resident Quality Inspection - Compliance Order was issued

(665)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Dec 21, 2017

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

## RENSEIGNEMENTS 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)<br>151, rue Bloor Ouest, 9e étage<br>Toronto ON M5S 2T5 | Directeur<br>a/s du coordonnateur/de la coordonnatrice en matière d'appels<br>Direction de l'inspection des foyers de soins de longue durée<br>Ministère de la Santé et des Soins de longue durée<br>1075, rue Bay, 11e étage<br>Toronto ON M5S 2B1<br>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 11th day of September, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

Ontario

**Ministry of Health and Long-Term Care**

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

**Ministére de la Santé et des Soins de longue durée**

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

**Name of Inspector / Nom de l'inspecteur :** Joy Ieraci

**Service Area Office / Bureau régional de services :** Toronto Service Area Office