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 prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 07, 2019	2018_578672_0008 (A1)	005359-18	Resident Quality Inspection

Licensee/Titulaire de permis

Southlake Residential Care Village
596 Davis Drive NEWMARKET ON L3Y 2P9

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

Southlake Residential Care Village
640 Grace Street NEWMARKET ON L3Y 2P6

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

Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

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

Compliance date extended from December17, 2018, to February 28, 2019, as per the Southlake Administrator's request

Issued on this 7 th day of February, 2019 (A1)

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

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Amended by JENNIFER BATTEN (672) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): April 10, 11, 12, 13, 17, 18, 19, 20, 23, 24, 26, 27, 30 and May 1, 2018

The following logs were inspected during this inspection:

Log #029263-17, Log #007997-17, and Log #024345-17, all related to critical incidents which occurred in the home, and were submitted to the Director specific to resident falls.

Log #003589-17, related to a complaint which was received regarding concerns specific to resident care.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Associate Directors of Care (ADOC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Registered Dietitian (RD), Environmental Services Manager (ESM), Wound Care Champion (WCC), Physiotherapists (PT), housekeeping and maintenance staff, Physicians, Behavioural Supports Ontario RPN (BSO RPN), Food Services Manager (FSM), residents, families, and volunteers.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Dignity, Choice and Privacy
Falls Prevention
Family Council
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.
- **17 WN(s)**
- **10 VPC(s)**
- **4 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

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

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to resident #031.

Resident #031 was admitted to the home on a specified date, with specified medical diagnosis. Resident #031 also had skin integrity concerns, which the physician was aware of, and had a specified treatment ordered for the area.

Inspector #672 reviewed the current written plan of care for resident #031, which had a focus specific to the specified area of altered skin integrity. There were interventions listed for the staff to implement, along with weekly skin assessments.

Inspector #672 reviewed the progress notes for resident #031 for a specified time period, which revealed that the area of altered skin integrity was first noted on a specified date. On a later date, the area was noted to have healed, and on a specified date, the treatment to the area and weekly skin assessments were discontinued.

During an interview, PSW #141 indicated that the skin integrity concern related to resident #031 had healed, and staff had no longer been applying the treatments to the area. PSW #141 further indicated that the registered staff were aware that the area had healed, as was the physician, which led to the treatment being discontinued.

During an interview, RPN #103 indicated that resident #031 only had an identified skin integrity concern, as the area of altered skin integrity had healed several months previously. RPN #103 further indicated that the expectation in the home was that the resident's written plan of care be kept current and up to date.

During an interview, the Wound Care Champion, RN #131, indicated the expectation in the home was that written plans of care were kept current, and listed information such as the first date a resident was noted to have any skin integrity issue, along with the location, treatment, and interventions implemented. Once an area was healed, it should either be removed from the written plan of care altogether, or revised to indicate the resident had a 'history of' the skin integrity concern.

During an interview, the DOC indicated that the expectation in the home was that the registered staff on the units were in charge of ensuring the resident's written plans of care were kept current and up to date, which were to reflect any current skin integrity issues, the goals for the area, and the interventions being implemented.

The licensee failed to ensure that the plan of care set out clear directions to staff who provided direct care to resident #031, related to skin integrity concerns which had been resolved at a specified time, but still appeared as active on the current written plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #023's written plan of care set out clear directions to staff who provided direct care to the resident.

Related to Log#029263-17:

A Critical Incident Report (CIR) was submitted to the Director, related to a fall sustained by resident #023 on a specified date, which resulted in an injury. At the time of the fall, resident #023 also had another injury present, due to a

previous fall. According to the CIR, resident #023 had sustained a specified number of falls during a specified time period. The CIR further stated that resident #023 exhibited identified behaviours, therefore staff were to remain with the resident, while the resident was being assisted with toileting.

Inspector #672 reviewed the progress notes for resident #023 during a specified time period. The progress notes indicated that resident #023 sustained a specified number of falls during that time period.

During an interview, ADOC #107 indicated that instructions had been provided to the registered staff on resident #023's home area to ensure the written plan of care was reviewed and revised following a specified fall, to include a specified intervention.

During separate interviews, PSW #154 and RPN #152 indicated that resident #023 had specified falls prevention interventions in place. RPN #152 further indicated that resident #023 required an identified mobility device for mobility purposes, and a specified level of assistance with transfers, due to specified physical conditions.

Inspector #672 reviewed the written plan of care for resident #023 in place following the fall listed in the CIR submitted to the Director. The written plan of care did not indicate two specific interventions, resident #023's identified risk for falls, the number of falls sustained within a specified time period, nor identified behaviours. The written plan of care did state that resident #023 utilized an identified mobility device (which was different than the mobility device staff indicated the resident utilized), and required a specified level of staff assistance. The written plan of care further indicated that an identified mobility device was only to be utilized during a specified time, therefore staff were to ensure a specified intervention was in place prior to utilizing the mobility device, and that frontline staff were to report to registered staff any change in resident #023's ability to use the identified mobility device.

The licensee failed to ensure that the written plan of care for resident #023 provided clear direction to staff who provided direct care to the resident, specific to fall prevention interventions. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the care set out in the written plan of care was provided to the resident as specified in the plan.

On a specified date, the MOHLTC received a complaint related to allegations of resident abuse, pain management, and lack of assessments regarding resident #001.

A review of the letter of concern received by the MOHLTC indicated that resident #001 was admitted to the home on a specified date, from a specified health facility. During the initial admission conference, members of the interdisciplinary team in attendance communicated to the Substitute Decision-Maker(s) (SDM) that they had requested the resident's medical records from the specified health facility, and as of the meeting, they had not arrived. The letter further documented that the resident required further specified tests due to a specified reason. The SDM requested a referral to an external specialist, as the pre-scheduled appointment had to be cancelled.

A review of the discharge patient summary faxed from the specified health facility to the home indicated that specified tests were scheduled to take place on a specified date. A review of the physician's order dated and signed off by registered staff member #127, ordered staff to obtain clarification on the resident's medical history to verify history of an identified medical condition, specified specialists, and required monitoring. Upon review of the resident's health records including the discharge patient summary and progress notes for a specified period of time, indicated that the physician made several inquiries related to the status of the requested information however, it was unavailable in the home. Registered staff #127, who signed off the physician's order was unavailable for an interview. Review of resident #001's health records did not produce any documentation to support that the physician's order was carried through, or that a request for additional information was made.

Interviews held with attending physician #124, registered staff member #'s 125, 128, and the Executive Director (ED) acknowledged that a reasonable time frame for completion of physician's orders had not been established, however, registered staff member(s) of the home should have conducted a follow up promptly to avoid delay in providing care to resident #001. Further interview with the ADOC's, attending physician, and the ED confirmed that the care set out in the written plan of care was not provided to resident #001 as specified in the plan. [s. 6. (7)]

4. The licensee has failed to ensure that the care set out in the plan of care for

resident #006 was provided to the resident as specified in the plan.

Inspector #672 reviewed resident #006's progress notes from a specified date, which indicated that resident #006 was noted to have an identified physical condition, related to an identified responsive behaviour. The progress note further indicated that resident #006 had a history of the identified responsive behaviour, and staff removed identified articles from resident #006's room, which the resident utilized during the exhibited identified responsive behaviour. Inspector #672 then expanded the review of the progress notes for a specified time period, and observed resident #006 had several instances of being found with a physical condition due to the exhibited identified responsive behaviour.

A record review of the progress notes for a specified time period, revealed that resident #006 had a history of an exhibited responsive behaviour, which caused a physical condition. On a specified date, resident #006 was observed to have another physical condition related to the exhibited responsive behaviour, and received medical treatment for a specified period of time.

Inspector #672 reviewed the most recent written plan of care for resident #006, which indicated that staff were to implement a specified intervention a specified number of times each shift, related to the identified exhibited responsive behaviour.

During an interview, PSW #111 indicated that a specified intervention was never implemented, but if a PSW staff member saw a possible reason to implement a specified intervention, they would bring it to the attention of the RPN, and have the RPN implement the specified intervention.

During an interview, PSW #134 indicated that the specified intervention was implemented a specified number of times, not the amount of times stated in the written plan of care.

During an interview, the BSO RPN indicated that the specified intervention was implemented a specified number of times, not the amount of times stated by PSW #134 or indicated in the written plan of care.

During an interview, RPN #112 indicated that the specified intervention was implemented a specified number of times, not the amount of times stated by PSW #134, the BSO RPN, or indicated in the written plan of care.

During an interview, ADOC #107 indicated that the expectation in the home was that the resident's plan of care was followed at all times, and if front line staff noted that changes needed to be made to the plan of care, this was to be reported to the registered staff on duty, and the registered staff were to assess the situation, and make the changes, as required, to the resident's written plan of care.

The licensee has failed to ensure that staff provided care to resident #006 as stated in the written plan of care. [s. 6. (7)]

5. The licensee has failed to ensure that when a resident is reassessed and the plan of care is reviewed and revised, the licensee shall ensure that different approaches are considered in the revision of the plan of care if the care set out in the plan of care has not been effective.

Related to Log#029263-17:

A Critical Incident Report (CIR) was submitted to the Director, related to a fall sustained by resident #023 on a specified date, which resulted in an injury. At the time of the fall, resident #023 also had another injury present, due to a previous fall. According to the CIR, resident #023 had sustained a specified number of falls during a specified time period.

Inspector #672 reviewed the progress notes for resident #023 for a specified period of time. The progress notes indicated that resident #023 sustained a specified number of falls during that time period. A fall sustained on an identified date, resulted in a specified injury, and a fall sustained on a different date, resulted in another injury.

Inspector #672 reviewed the plan of care for resident #023 for identified time periods, which revealed that at a specified time, resident #023 required a specified level of staff assistance for an identified activity of daily living, due to identified medical conditions. Due to this, resident #023 utilized a specified assistive mobility device for most mobility needs. The plan of care further indicated that resident #023 had an identified level of cognitive impairment, with specified deficits.

Inspector #672 then reviewed the post fall assessments completed between a

specified time period, which indicated that the resident sustained a specified number of falls during that time period. There were identified falls prevention interventions listed within resident #023's plan of care.

Inspector #672 reviewed resident #023's plan of care after each of the falls sustained during a specified time period, and no evidence was observed that different approaches were considered for the resident, following any of the falls sustained. The post fall assessments indicated that resident #023 would frequently exhibit an identified behaviour, which resulted in the resident falling due to specified reasons and medical conditions. The post fall interventions listed within the assessments in an attempt to prevent further falls from occurring were to make sure the call bell was within resident #023's reach, and remind the resident to call for assistance.

Inspector #672 then reviewed the plan of care between an identified time period, which indicated the resident sustained a specified number of falls during that time period. The falls prevention interventions listed within the plan of care included the same interventions listed in the plan from a previous time period, with no evidence observed that different approaches were considered, for the purposes of falls prevention. During a review of the progress notes for a specified time period, it was revealed that resident #023 sustained a fall on a specified date, which resulted in an injury, after the resident fell following an exhibited identified behaviour. This fall resulted in the resident being required to receive a specified medical intervention. There was no evidence observed that new interventions or approaches were considered related to the fall sustained, the specified medical intervention, or any change to the resident's care needs. A review of resident #023's health care record indicated that resident #023 continued to sustain falls following the fall with the specified injury, with falls sustained on specified dates, as a result of the resident continuing to exhibit identified behaviours. The fall sustained on a specified date, resulted in another specified injury, after resident #023 was left alone in an identified area.

Inspector #672 then reviewed resident #023's plan of care for a specified period of time, which indicated that different approaches were not considered following the fall sustained on a specified date, until a future specified date, when specified interventions were listed.

There were no new interventions observed related to attempting to prevent further falls from occurring.

A review of resident #023's plan of care for a specified period of time, revealed that resident #023 sustained another fall on a specified date, after exhibiting the same identified behaviour. After this fall, ADOC #107 reviewed and revised the resident's plan of care, and implemented different approaches.

Inspector #672 reviewed resident #023's plan of care for a specified period of time, which revealed that resident #023 had not sustained any further falls, after the plan of care was reviewed and revised by ADOC #107, and different approaches and interventions were implemented.

During an interview, RPN #152 indicated that different approaches were not routinely considered or implemented following each resident fall, due to a belief that "falls will just happen, unless you restrain the resident to the bed or chair". RPN #152 further indicated that if a resident's plan of care was to be reviewed, it would only be reviewed and revised on the day shift, even when a fall occurred on the evening or night shift, as it was only the responsibility of the day shift nurse to review and revise the resident's plans of care, and implement new/different approaches for the resident. RPN #152 indicated that resident #023 had a specified medical condition, which resulted in the staff implementing specified interventions, otherwise the resident would continue to exhibit an identified behaviour. RPN #152 further indicated that the interventions listed within resident #023's plan of care between a specified time period had not been effective, as some of the interventions listed were not appropriate for the resident at that time. RPN #152 indicated these interventions were not effective due to identified reasons. RPN #152 also indicated that the falls prevention interventions for resident #023 had not been effective, as evidenced by the resident continuing to sustain multiple falls during that time period. RPN #152 indicated that when resident #023's plan of care was reviewed and revised following the fall sustained on a specified date, when different falls prevention approaches were considered and implemented, the new approaches were effective, as resident #023 had not sustained any further falls afterward.

During an interview, RPN #131 indicated that different approaches were not routinely considered or implemented following each resident fall. RPN #131 further indicated that the interventions listed in resident #023's plan of care during a specified time period, had not been effective, as evidenced by resident #023 sustaining multiple falls during that time period.

During an interview, ADOC #107 indicated that it was the responsibility of the registered staff on each shift to update the resident's plan of care as necessary, when an intervention needed to be added, revised, or discontinued. ADOC #107 further indicated that the expectation in the home was that each resident's plan of care was reviewed and revised, with different approaches considered, following each resident fall, regardless of the severity of the fall, or if injuries were sustained. ADOC #107 indicated that the fall sustained by resident #023 on a specified date, occurred as a result of different falls prevention interventions and approaches not being considered or implemented following previous falls sustained. As a result, the resident continued to exhibit an identified behaviour. ADOC #107 further indicated that the different approaches related to falls prevention which had been considered and implemented for resident #023 when they updated the resident's plan of care had been effective, as the resident had not sustained any further falls since the new approaches were implemented.

The licensee failed to ensure that when resident #023's plan of care was revised, due to the care in the plan being ineffective, that different approaches were considered in the revision of the plan of care, in an attempt to prevent further falls from occurring. When the licensee did consider different approaches and interventions after the resident sustained a specified number of falls in a specified time period, which resulted in the resident sustaining a specified number of injuries, the new approaches were effective. This was evidenced by resident #023 not sustaining any further falls once the different approaches and interventions were implemented. [s. 6. (11) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

During the initial tour of the home, Inspector #672 made the following observations:

• On an identified resident home area, the door to the storage room in the north hall could be pushed open. There were Oxivir wipes, Personal Protective Equipment (PPE), and other supplies stored within the room. There were no staff observed to be in the immediate area.

RPN #109 confirmed that the door to the storage room was not locked, and could be opened, at a specified time.

• On an identified resident home area, the door to the nursing station was left open, with no staff observed to be in the immediate area, and several residents sitting in the lounge area just outside the staff room. Resident's confidential charts and oxygen supplies were stored within the room.

On a specified date, Inspector #672 made the following observations at a specified time:

• On an identified resident home area, the door to the nursing station was observed to be left open, with no staff members present, and three residents sitting in the immediate area. Resident's confidential charts and other supplies

were stored within the room.

On a specified date, Inspector #672 made the following observations:

• On two identified resident home areas, the doors to the nursing station were observed to be left open, with no staff members present. Resident's confidential charts, a specimen fridge, and other supplies were stored within the room.

• On an identified resident home area, the door to the storage room in the north hall could be pushed open. There were Oxivir wipes, PPE equipment, and other supplies stored within the room.

On a specified date and time, Inspector #672 made the following observation:

• On an identified resident home area, the door to the nursing station was observed to be left open, with no staff members present, and several residents sitting in, and/or walking past the immediate area, on their way to the dining room for lunch. Resident's confidential charts, and other supplies were stored within the room.

During separate interviews, PSW #111, and RPNs #102, #104, and #109, and the Executive Director (ED) indicated that the nursing stations were non-residential areas, and the expectation in the home was that the door was to be kept closed and locked when staff were not in the immediate area.

During separate interviews, RPN #109 and the ED indicated that all storage rooms in the home were considered to be non-residential areas, and the doors should be kept closed and locked at all times, unless there was a staff member removing an item from the storage room.

On a specified date and time, Inspector #672 made the following observation:

• The door to an identified area was left wide open, with no staff in the immediate area. There were multiple residents in the area, either walking by the room, or sitting in the area. Within the identified area were multiple bottles of chemicals, such as "Barbicide", "Cool Mist Astringent", Isopropyl Rubbing Alcohol, multiple bottles of "Neutralisant" hair chemical, hair dyes and solutions. There was also a complete resident list sitting on the counter, which included the resident's full name and room number. After waiting for a specified period of time for a staff

member to return, Inspector #672 reported to the receptionist that the door was left open, with no staff members noted to be in the area. The receptionist indicated that the door to the salon was left open, as it was supposed to be receiving a "deep clean". No housekeeping or maintenance staff were observed to be in the immediate area, and no cleaning equipment was observed.

During an interview, the DOC indicated that the expectation in the home was that all doors leading to non-residential areas were kept closed and locked at all times, when staff were not in the immediate area, and that the hair salon was considered to be a non-residential area when staff were not present.

The licensee has failed to ensure that all doors to non-residential areas were kept closed and locked when they were not being supervised by staff. [s. 9. (1) 2.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(h) residents are provided with a range of continence care products that,
(i) are based on their individual assessed needs,
(ii) properly fit the residents,
(iii) promote resident comfort, ease of use, dignity and good skin integrity,
(iv) promote continued independence wherever possible, and
(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Inspector #110 reviewed the MDS quarterly review assessment for resident #022, which identified the resident as exhibiting a specified level of continence. The prior MDS assessment identified the resident as exhibiting a different level of continence. This change would be considered a continence decline.

During separate interviews, RPN #112 and RN #144 confirmed to Inspector #110 that a specified change in a resident's continence level would be considered a deterioration in the resident's continence status. RN #144 further confirmed that the registered staff were to complete a continence assessment when an assessed decline in continence status was identified in the resident at a minimum of quarterly. RN #144 confirmed there was no continence assessment completed as expected for resident #022, related to the assessed decline identified in the

identified MDS assessment.

During an interview with Inspector #110, ADOC #106 indicated being the lead for the continence program in the home. ADOC #106 further confirmed that registered staff had not completed a continence assessment as required for resident #022, who experienced a deterioration in their continence level. [s. 51. (2) (a)]

2. Resident #006 triggered during Stage 1 of the RQI, related to their identified risk for incontinence, while exhibiting a specified level of continence, according to the most recent assessment.

Inspector #110 reviewed resident #006's MDS quarterly review assessment, which identified resident #006 as exhibiting a specified level of continence. The prior MDS assessment identified the resident as exhibiting a different level of continence. This change would be considered a continence decline.

During separate interviews with Inspector #110, PSWs #142 and #111 did not confirm a decline of resident #006's continence over this identified time period.

During an interview, RPN #143 revealed to Inspector #110 that when a decline in a resident's continence status was identified during the MDS assessment, the registered staff would complete a continence assessment for the resident. RPN #143 confirmed that resident #006 was identified to exhibit a continence decline in an identified MDS assessment, but there was no corresponding continence assessment completed as expected.

During an interview with Inspector #110, RPN #112 identified in the Point Of Care documentation, that the PSW documentation for an identified MDS assessment should have indicated the resident exhibited specified levels of continence, and confirmed a decline in resident #006's continence. RPN #112 further indicated that the expectation in the home was that a continence assessment was required to be completed quarterly, and with any deterioration identified in a resident's continence level. RPN #112 indicated that a continence assessment had not been completed for resident #006, as required.

During the record review, Inspector #110 reviewed the licensee's continence policy, entitled "Continence Management Program"; RC-14-01-01; dated February 2017; which identified the following:

"1. Complete a Continence Assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. An assessment is completed:
b. With any deterioration in continence level and
c. At required jurisdictional frequency".

During an interview, ADOC #106 indicated being the lead for the continence care program in the home. ADOC #106 further confirmed that registered staff had not completed a continence assessment as required for resident #006, who experienced a deterioration in their continence level. [s. 51. (2) (a)]

3. Resident #021 triggered during stage 1 of the RQI, related to being identified as a specified risk for incontinence while exhibiting a specified level of continence, according to the most recent assessment.

During the record review, Inspector #110 reviewed the MDS quarterly assessment, which identified resident #021 as exhibiting a specified level of continence. The prior MDS assessment identified the resident as exhibiting a different level of continence. This change would be considered an improvement in the resident's continence level.

Inspector #110 reviewed the PSW documentation specific to a specified look back period MDS assessment, which identified that resident #021 exhibited a specified level of continence.

During separate interviews with Inspector #110, PSWs #153 and #111 indicated that resident #021 exhibited a specified level of continence, and no change or improvement in their continence level had occurred.

During an interview with Inspector #110, RPN #112 indicated the MDS documentation for a specified time period, was incorrect, and resident #021 exhibited a specified level of continence, not the level of continence as identified in the MDS assessment. RPN #112 further indicated that resident #021 should have had a continence assessment completed as part of the quarterly MDS review during a specified time period, and identified that a continence assessment had not been completed for this resident since a specified time.

During the record review, Inspector #110 reviewed the licensee's continence policy entitled "Continence Management Program"; RC-14-01-01; dated February

2017, which identified the following:
"1. Complete a Continence Assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. An assessment is completed:
b. With any deterioration in continence level and
c. At required jurisdictional frequency".

During an interview, ADOC #106 indicated being the lead for the continence care program in the home. ADOC #106 further confirmed that registered staff had not completed a continence assessment as required for resident #021, who experienced a deterioration in their continence level. [s. 51. (2) (a)]

4. The licensee has failed to ensure that residents were provided with a range of continence care products, based on their individual assessed needs.

Resident #022 triggered in Stage 1 of the RQI, related to the resident's identified risk for incontinence, while exhibiting a specified level of continence, according to the most recent assessment.

During an interview with Inspector #110, resident #022 identified they required a specified level of assistance with toileting, and wore a specified continence product, due to an identified reason. Resident #022 told Inspector #110 that they gave money to their family member, who bought the identified continence product, which created a significant financial hardship for the resident. Inspector #110 observed a package of the identified continence products in resident #022's closet.

During an interview with Inspector #110, PSW #145 identified that resident #022 usually exhibited an identified level of continence, and wore a specified continence product, for specified reasons. PSW #145 further identified that resident #022's family paid for the specified continence product, and the specified continence products were not available as part of the range of continence care products in the home.

During an interview with Inspector #110, PSW #146 identified that resident #022 preferred to wear the specified continence product, for a specified reason.

Inspector #110 reviewed resident #022's plan of care, which identified that resident #022 wore the specified continence product, which were provided by the

family.

Inspector #110 reviewed the "Resident Product List" for resident #022's resident home area, which identified resident #022 required the specified continence product during the day, evening, and night shifts. A further review of the "Resident Product List" for for resident #022's resident home area, identified residents #026 and #027 required the specified continence products as part of their continence care needs.

During separate interviews with Inspector #110, residents #026 and #027 confirmed they also independently purchased their specified continence products.

During an interview with Inspector #110, RPN #147 indicated that the 'Resident Product List' was based on the resident's assessed needs, and confirmed that the specified continence products were required by residents #022, #026 and #027, during the day, evening, and night shifts. RPN #147 further indicated that the home did not provide the specified continence products as part of the continence care products available to the residents in the home, therefore the residents or their families were required to pay for the specified continence products.

During an interview with Inspector #110, ADOC #106 confirmed that the 'Resident Product List' regarding continence care products was based on the resident's assessed needs. ADOC #106 further identified that families were required to pay for the specified continence products, and that the specified continence products were not available in the home, as part of the range of continence care products. ADOC #106 confirmed that there were currently an identified number of residents in the home who required the specified continence products, who were paying for the products independently, due to the products not being provided by or paid for by the home. [s. 51. (2) (h) (i)]

Additional Required Actions:

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

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents #014, #030, and #031 were assessed by the Registered Dietitian, who was a member of the staff of the home; and any changes made to the resident's plan of care related to nutrition and hydration specific to skin integrity concerns, were implemented.

During transition from Stage I to Stage II of the RQI, Skin and Wound care issues triggered through to Stage II for resident #014, related to staff reporting that resident #014 had alterations in skin integrity.

Inspector #672 observed during Stage II of the RQI, that resident #014 had alterations in skin integrity.

During an interview, RPN #104 indicated that resident #014 did have alterations in skin integrity. RPN #104 further indicated that the expectation in the home was that referrals to the Registered Dietitian (RD) were to be completed for all residents exhibiting altered skin integrity, such as skin tears, bruising, or pressure ulcers of Stage II or greater. RPN #104 indicated that all RD referrals should be documented under the 'Assessments' section in PCC, but could not recall submitting an RD referral for resident #014, related to any of the alterations in skin integrity.

During an interview, Wound Care Champion (WCC) #131 indicated the expectation in the home was that a referral was sent to the RD for any new, worsening, or change in skin integrity concerns. WCC #131 further indicated that it was the responsibility of the Registered Staff on the resident home area to send a referral to the RD, if a resident had skin integrity concerns.

Inspector #672 reviewed the progress notes in PCC for resident #014 during a specified time period. The progress notes indicated that on a specified date, there were no observed skin integrity concerns for resident #014. On a later specified date, there was documentation which stated that resident #014 had an alteration in skin integrity. The progress notes further indicated that on a specified date, there was another alteration in skin integrity; on a specified date, there was a different alteration in skin integrity; and on a specified date, there was an alteration in skin integrity to another identified area.

Inspector #672 reviewed the 'Assessments' section in PCC for resident #014 for a specified time period, and did not observe any referrals sent to the RD, related to skin and wound concerns, specific to resident #014's alterations in skin integrity.

During an interview, the RD indicated not being aware that resident #014 had specific alterations in skin integrity. The RD further indicated that the knowledge they did posses of the resident's alterations in skin integrity was gained through the RD's completion of the quarterly resident review, not through any referrals sent. The RD indicated that the expectation in the home was that referrals should be sent to the RD with any change in skin integrity, which included all bruises, abrasions, skin tears, or pressure ulcers; and all new, worsening, or any other change in condition to a current wound status. The RD indicated that if a referral had been sent related to the alterations in skin integrity for resident #014, an specified order would have been given.

Inspector #672 expanded the scope of residents inspected to three, due to the non-compliance noted related to resident #014, and inspected resident #030, who had alterations in skin integrity; and to resident #031, who also had alterations in skin integrity.

During an interview, RPN #109 indicated that resident #030 had an identified alteration in skin integrity, which required routine identified treatment. RPN #109 further indicated that the expectation in the home was that a referral should be sent to the RD for all resident wounds, or altered skin integrity.

Inspector #672 reviewed the 'Assessments' section for resident #030 in PCC for a specified time period, which revealed that on a specified date, an assessment of skin impairment was completed, which noted there was a skin integrity issue related to resident #030. On another specified date, there was a referral completed to the WCC, related to the resident's alteration in skin integrity.

Inspector #672 reviewed all progress notes for resident #030 completed in PCC for a specified time period, which revealed the resident had multiple instances and areas of alterations in skin integrity.

During an interview, the RD indicated not being aware that resident #030 had current alterations in skin integrity, and was not aware of any of the resident's alterations in skin integrity between a specified time frame.

Resident #031 was admitted to the home on a specified date, with multiple medical diagnoses.

During an interview, RPN #103 indicated that resident #031 had alterations in skin integrity, which required routine identified treatment. RPN #103 further indicated that the expectation in the home was that upon original discovery of an area of altered skin impairment, a referral should be sent to the RD for assessment and follow up.

Inspector #672 reviewed the 'Assessments' section in PCC for resident #031 for a specified time period, which revealed that resident #031 had alterations in skin integrity. The assessments further indicated that the alterations in skin integrity worsened over time, which led to a medical condition; along with sustaining other alterations in skin integrity.

Inspector #672 reviewed the progress notes in PCC for resident #031 for a specified time period, which revealed the resident had multiple instances and areas of alterations in skin integrity.

During an interview, the RD indicated not being aware that resident #031's alterations in skin integrity had worsened, or that the alterations in skin integrity led to a medical condition, until a specified date, when completing the dietary quarterly review, and reviewed resident #031's progress notes as part of the dietary quarterly summary. The RD indicated not receiving referrals related to the progression of the alterations in skin integrity or medical condition, except for one concern on a specified date. The RD further indicated that referrals should be sent to the RD by the Registered Staff related to skin tears, bruising, ulcers, and abrasions; along with any new skin integrity concerns.

During an interview, the DOC indicated that the expectation in the home was that referrals were sent to the RD by the Registered Staff for any new or worsening skin integrity concern, so that the RD could assess the nutrition and hydration aspects of each resident, related to skin integrity issues.

The licensee failed to ensure that resident #014, #030, and #031 were assessed by the Registered Dietitian for all new, and/or worsening skin integrity concerns. [s. 50. (2) (b) (iii)]

2. The licensee has failed to ensure that residents #014, #030, and #031 were reassessed by an RN at least weekly, when clinically indicated, due to exhibited altered skin integrity.

During transition from Stage I to Stage II of the RQI, Skin and Wound care issues triggered through to Stage II for resident #014, related to staff reporting that resident #014 had alterations in skin integrity present.

Inspector #672 observed during Stage II of the RQI, that resident #014 had alterations in skin integrity.

During an interview, RPN #104 indicated the expectation in the home was that every identified area of altered skin integrity should be assessed and documented on, on a weekly basis.

Inspector #672 reviewed the internal policy related to identified areas of altered

skin integrity, Policy Number: 03-07, Date of Origin: June 2010, which stated the following:

"The Skin Care Coordinator or delegate will assess and document the assessment of all identified areas of altered skin integrity that are assessed at an identified stage weekly."

The policy went on to state under the 'Documentation' heading:

• "Altered Skin Care Record – used to document the status of the identified area of altered skin integrity

• Progress notes – used to document the progression of altered skin healing, resident response to treatment, assessments completed and any other care related interventions associated with the identified area of altered skin integrity such as referrals to specialists etc."

Inspector #672 reviewed all progress notes for resident #014 for a specified time period, which revealed that on a specified date, resident #014 was observed to have an alteration in skin integrity, and on a future specified date, was noted to have another alteration in skin integrity. On another specified date, the progress notes indicated that resident #014 other alterations in skin integrity.

Inspector #672 reviewed the assessments section and progress notes for resident #014 in Point Click Care (PCC) for a specified time period, which revealed the following:

• A specified alteration in skin integrity was first noted on a specified date. There were assessments completed on two specified dates, but not on two other specified dates.

• During a specified month, there were assessments completed regarding the specified alteration in skin integrity on three specified dates, but not on one other specified date.

• During a specified month, there were assessments completed regarding the specified alteration in skin integrity on two specified dates, but not on two others.

• During a specified month, there were assessments completed regarding the

specified alteration in skin integrity on three specified dates, but not on one other.

Related to a second specified alteration in skin integrity, Inspector #672 reviewed the documentation in PCC for a specified time period, which revealed the following:

• The second specified alteration in skin integrity was first noted on a specified date. There were assessments completed regarding the second specified alteration in skin integrity on one date, but not on one other specified date.

• During a specified month, there were assessments completed regarding the second specified alteration in skin integrity on one specified date, but not on three others.

• During a specified month, review of the documentation revealed that the area was not assessed and documented on at all during the month,.

• During a specified month, there were assessments completed regarding the second specified alteration in skin integrity on one specified date, not on three others.

Related to a third specified alteration in skin integrity, the documentation in PCC was reviewed for a specified time period, which revealed the following:

• The third specified alteration in skin integrity was first noted on a specified date. Review of the documentation revealed that after the area was first noted, there was no further assessment of, or documentation on the area during a specified month.

• During a specified month, there were assessments completed on the third specified alteration in skin integrity on one specified date, but not on four others.

Inspector #672 expanded the scope of residents inspected to three, related to the non-compliance noted in resident #014's current plan of care, and inspected resident #030, who had alterations in skin integrity, and resident #031, who also exhibited alterations in skin integrity.

Resident #030 was admitted to the home on a specified date, with specified

medical diagnoses. Resident #030 was noted to have an alteration in skin integrity.

During an interview, RPN #109 indicated that resident #030 currently had an alteration in skin integrity, which required a specified treatment.

Inspector #672 reviewed all progress notes and assessments for resident #030 for a specified period of time. Review of the progress notes revealed that on a specified date, an assessment of skin impairment was completed, which noted there was a skin integrity issue present. Inspector #672 reviewed the assessments section and progress notes for resident #030 in Point Click Care (PCC) for a specified period of time, which revealed the following:

• Resident #030's alteration in skin integrity was first noted on a specified date. There were assessments completed on two dates, but not on two others.

• During a specified month, there were no assessments with documentation completed.

During an interview, RPN #109 indicated the expectation in the home was that every specified skin integrity concern should be assessed and documented on, on a weekly basis.

Resident #031 was admitted to the home on a specified date, with identified medical diagnoses. Resident #031 also had specified skin integrity concerns.

During an interview, RPN #103 indicated resident #031 had an alteration in skin integrity, with several interventions in place. Resident #031 also received specific skin integrity treatments, due to a medical condition.

Inspector #672 reviewed the progress notes and assessment section in PCC for resident #031 for a specified period of time. Review of the progress notes revealed that on a specified date, an identified alteration in skin integrity was present. Inspector #672 reviewed the assessments section and progress notes for resident #031 in PCC for a specified period of time, which revealed the following:

• During a specified month, there were assessments related to the identified alteration in skin integrity completed on two specified dates, but not on three

others.

• During a specified month, there were assessments related to the identified alteration in skin integrity completed on two specified dates, but not on three others.

During an interview, the Wound Care Champion (WCC), RN #131 indicated that part of the role of the WCC was to ensure that each identified area of altered skin integrity received a weekly assessment with corresponding documentation, but approximately one year ago, the WCC informed the DOC that not enough time was allocated in the role of the WCC for that task to be completed, therefore the task was transferred to the RPNs on the units to complete. The WCC further indicated that all of the RPNs had received education and training regarding specific areas of altered skin integrity care, the internal Skin and Wound Care policies and procedures, and the expectations in the home regarding weekly assessments and documentation, prior to taking over responsibility of the weekly altered skin assessments.

During an interview, the DOC indicated being aware that the weekly altered skin integrity assessments and documentation were not being completed, after being informed by the WCC approximately one year ago. The DOC further indicated there was not currently a plan in place for ensuring that the weekly areas of altered skin integrity assessments were being completed by the nursing staff.

The licensee failed to ensure that residents #014, #030, and #031 were reassessed by an RN at least weekly, when clinically indicated, due to exhibited altered skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 004

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee had failed to ensure that any plan, policy, protocol, procedure, strategy, or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place had been complied with.

According to O. Reg. 79/10, s. 68 (2) e, The licensee shall ensure that the nutrition care and hydration program includes a weight monitoring system to measure and record with respect to each resident, (i) weight on admission and monthly thereafter, and (ii) body mass index and height upon admission and annually thereafter.

A review of the home's policy titled "Height and Weight Monitoring #RC-18-01-06" last updated February 2017, indicated the following:

"1. Compare to previous month's weight; any weight with a 2.5 KG difference from the previous month requires a re-weigh to ensure accuracy. The nurse will direct care staff to re-weigh the resident. Homes may record this electronically or use the Weight Change Program Tracking Sheet, Appendix 3.

2. Ensure current, accurate weight of individual resident, including re-weigh if applicable, is recorded by the 10th day of each month either on paper or electronically and entered in resident's health care record".

During stage one of the RQI, resident #013 triggered related to weight loss.

A review of resident #013's weight summary on PCC indicated the resident was weighed on a specified date, and when weighed one month later, had an identified weight loss of a specified amount. There was no information obtained from resident #013's weight summary and progress notes on PCC to indicate that a re-weigh had been completed.

Interviews with RPN #104, the Registered Dietitian (RD), and the Food Services Manager (FSM), acknowledged the specified weight difference between a specified one month time period. The RPN, RD, and the FSM confirmed that resident #013 had not been re-weighed to ensure accuracy of their weight, as required by the home's policy. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system that the licensee was required by the Act or Regulation to have instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where a specified bed system and intervention was used for resident #004, the resident was assessed, and the bed system evaluated, in accordance with evidence-based practices, to minimize risk to the resident.

Resident #004 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of observations made during Stage I,

specific to the use of a specified bed system. During Stage I of the RQI, resident #004 was observed on a specified date, by Inspector #110 to have a specified bed system in place.

Resident #004 was admitted to the home on a specified date, with specified medical diagnoses.

Resident #004 was observed on a specified date, by Inspector #672, and observed to have a specified bed system in place.

On a specified date, Inspector #672 reviewed the current written plan of care for resident #004, along with the "Assessments" section in PCC, for a specified time period. There were no assessments observed related to the use or implementation of the specified intervention or PASD, nor of the bed system and/or entrapment. The current written plan of care did not have any focuses specific to the use of specified intervention as a PASD.

During an interview, PSW #115 indicated that resident #004 had a specified intervention in place, which was utilized as a PASD. PSW #115 further indicated that resident #004 utilized the specified intervention to assist with an activity of daily living.

During an interview, RPN #114 verified that resident #004 had a specified intervention present, which was utilized as a PASD. RPN #114 further indicated belief that only entrapment assessments were required to be completed when the resident was utilizing a specified bed system intervention, and that those assessments should be completed on admission to the home, annually, and if there were any concerns. RPN #114 indicated being unaware of why no entrapment assessments had been completed for resident #004 since admission to the home, and stated no other assessments had been completed on resident #004, due to the fact that the bed system in place had been a specified type of bed system intervention.

During an interview, the DOC indicated that the home used to have a lot of residents with a specified type of bed system/intervention in place, but the corporate office had started an initiative related to removing that specified bed system/intervention from resident bed systems, unless found to be necessary through resident assessments. When this initiative was brought forward, the home removed the specified bed system/intervention from most of the resident

beds in the home, and replaced them with another specified bed system/intervention, without conducting any sort of an assessment on the resident. The DOC further indicated that there was not currently any sort of a plan in the home for completing assessments on the residents with a specified bed system/intervention in place, in an effort to minimize risk to the resident.

The licensee failed to ensure that resident #004 was assessed, and the bed system evaluated, to minimize risk to the resident, with relation to the use of a specified intervention. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where a specified intervention was used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

Resident #004 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of observations made during Stage I, specific to the use of a specified intervention. During Stage I of the RQI, resident #004 was observed on a specified date, by Inspector #110 to have a specified intervention in place.

Resident #004 was observed on a specified date, by Inspector #672, and observed to have a specified intervention in place.

On a specified date, Inspector #672 reviewed the current written plan of care for resident #004, along with the "Assessments" section in PCC, for a specified time period. There were no assessments observed related to the use or implementation of the specified intervention or PASD, nor of the bed system and/or entrapment. The current written plan of care did not have any focuses specific to the use of the specified system as a PASD.

On a specified date, Inspector #672 reviewed the home's entrapment assessments binder, which indicated that no entrapment assessments had been completed in the home since a specified date.

During an interview, the Environment Services Manager (ESM) indicated it was part of the ESM role to complete the entrapment assessments on all resident bed systems, but no assessments had been completed in the home since a specified date. The ESM further indicated that during a specified time period, the home had purchased and put into use approximately 40 new resident beds, but none of

the beds had been assessed for entrapment risks prior to the residents using them.

During an interview, the ED indicated being unaware that entrapment assessments had not been completed in the home since a specified date, nor on the 40 new beds which had been put into service, but would follow up to ensure that all entrapment assessments were completed as soon as possible.

During an interview, the ED indicated that the entrapment assessments had been completed over the past weekend, and there were two beds in the home which had failed the entrapment assessments in two or more entrapment zones. The ED further indicated being unaware of what, if any, interventions had been put in place for the resident bed systems which had failed, in an attempt to minimize the risk for the residents.

During an interview, the ESM indicated that the entrapment assessments had been completed, and resident #028 and #029's beds had failed the entrapment assessments in two or more entrapment zones, due to a specified reason. The ESM further indicated being unaware of any interventions which had been put into place in an attempt to minimize the risk for residents #028 and #029, indicating that would be a nursing measure, not an environmental measure.

Resident #028 was admitted to the home on a specified date, with specified medical diagnoses.

Inspector #672 observed resident #028, and noted that resident #028 had a specified intervention in place.

During separate interviews, PSW #101 and RPN #102 both indicated being unaware of any entrapment risks for resident #028. PSW #101 indicated that no one had informed staff during shift report that any entrapment risks had been identified with the bed system for resident #028, and RPN #102 indicated that no one had informed the Registered staff of the risk to resident #028 either, therefore no interventions had been put in place, in an attempt to minimize the risk of entrapment.

Resident #029 was admitted to the home on a specified date, with specified medical diagnoses.

Inspector #672 observed resident #029. Resident #029 was observed to have a specified intervention in place.

During separate interviews, PSW #129 and RPN #103 indicated being unaware of any entrapment risks for resident #029. PSW #129 indicated that no one had informed staff during shift report that any entrapment risks had been identified with the bed system for resident #029, and RPN #103 indicated that no one had informed the Registered staff of the risk to resident #029 either. RPN #103 further indicated that due to not being aware that there were any identified entrapment risks with resident #029's bed system, no interventions had been put in place, in an attempt to minimize the risk of entrapment.

During an interview, ADOC #106 indicated being unaware that resident #028 and #029's bed systems had failed the entrapment assessments in two or more entrapment zones, due to a specified reason, therefore had not informed the staff on the resident home areas.

During an interview, ADOC #107 indicated recalling the ESM discussing that resident #028 and #029's bed systems failed the entrapment assessments in two or more entrapment zones, due to a specified reason, but believed the ESM had taken care of the entrapment risks, and did not recall hearing about any need to follow up, therefore had not informed the staff on the resident home areas.

The licensee has failed to ensure that where a specified intervention was used for resident #028 and #029, steps were taken to prevent resident entrapment, after both bed systems failed the entrapment assessment in at least two zones. [s. 15. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where bed rails are used, the resident is assessed and his or her bed system is evaluated in accordance with evidence based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; and that steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment,, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #032 was protected from abuse.

Related to Log#008544-18:

On a specified date, Inspector #672 was conducting an observation for resident #014, related to Stage II of the RQI. While Inspector #672 was standing in an identified area of a specified resident home area, Inspector overheard PSW #137 speaking to a resident in a very harsh tone, with strong language. Inspector #672 stepped forward from the hallway, to observe several residents present in the lounge area, along with PSW #137 stepping towards resident #032, after the resident had exhibited an identified responsive behaviour. PSW #138 and RPN #104 were also observed to be in the area. As soon as PSW #137 saw Inspector #672, the tone of voice immediately changed, and PSW #137 spoke to the resident in a pleasant tone. Resident #032 was removed from the identified area, and taken to their bedroom to be assisted.

Inspector #672 observed resident #032 to be emotionally upset and agitated, and did not want to cooperate with PSW #137. Once PSW #137 spoke to resident

#032 in a calmer and quieter tone of voice, resident #032 appeared to settle somewhat, and did cooperate with going to be assisted. During an interview, resident #032 was not able to discuss the incident, due to a medical condition.

During an interview, PSW #137 was unable to recall how they spoke to resident #032, when they first approached the resident. PSW #137 further indicated being "shocked and surprised" by resident #032's exhibited responsive behaviour.

This incident was reported to the ED by Inspector #672, who immediately informed the DOC, and PSW #137 was sent home, pending investigation into the incident.

During an interview, RPN #104 indicated that resident #032 had been observed exhibiting an identified responsive behaviour, but continued to administer a medication to a resident. RPN #104 further indicated overhearing PSW #137 speak to the resident in a loud voice, but had no concerns.

During an interview, PSW #138 indicated being in the identified area when resident #032 was observed to exhibit the identified responsive behaviour. PSW #138 further indicated this incident was reported to PSW #137, who was also approaching the identified area, so that PSW #137 could assist resident #032, due to PSW #137 being the primary PSW assigned to the resident. PSW #138 indicated belief that the way PSW #137 spoke to resident #032 was "not appropriate", and had planned to discuss PSW #137s actions with them, later during the shift.

During an interview, the DOC indicated that the home had a zero tolerance policy for resident abuse and/or neglect. The DOC further indicated that the interaction between resident #032 and PSW #137 did not meet the expectations in the home.

The licensee failed to ensure that resident #032 was protected from an incident of staff to resident abuse. [s. 19. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every resident of the home is protected from abuse, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 33. PASDs that limit or inhibit movement

Specifically failed to comply with the following:

s. 33. (3) Every licensee of a long-term care home shall ensure that a PASD described in subsection (1) is used to assist a resident with a routine activity of living only if the use of the PASD is included in the resident's plan of care. 2007, c. 8, s. 33. (3).

s. 33. (4) The use of a PASD under subsection (3) to assist a resident with a routine activity of living may be included in a resident's plan of care only if all of the following are satisfied:
1. Alternatives to the use of a PASD have been considered, and tried where appropriate, but would not be, or have not been, effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
2. The use of the PASD is reasonable, in light of the resident's physical and mental condition and personal history, and is the least restrictive of such reasonable PASDs that would be effective to assist the resident with the routine activity of living. 2007, c. 8, s. 33 (4).
3. The use of the PASD has been approved by,
i. a physician,
ii. a registered nurse,
iii. a registered practical nurse,
iv. a member of the College of Occupational Therapists of Ontario,
v. a member of the College of Physiotherapists of Ontario, or
vi. any other person provided for in the regulations. 2007, c. 8, s. 33 (4).
4. The use of the PASD has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 33 (4).
5. The plan of care provides for everything required under subsection (5). 2007, c. 8, s. 33 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD used to assist resident #004 with a routine activity of daily living was included in the resident's plan of care.

Resident #004 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of observations made during Stage I, specific to the use of a specified intervention. During Stage I of the RQI, resident #004 was observed by Inspector #110 to have the specified intervention in place.

During an interview, PSW #115 indicated that resident #004 had a specified intervention in place, which was utilized as a PASD. PSW #115 further indicated that resident #004 utilized the specified intervention related to an identified activity of daily living.

Inspector #672 reviewed the current written plan of care for resident #004, but could not locate any focus which indicated that resident #004 had the specified intervention in place, or was utilizing a PASD to assist with an activity of daily living.

During an interview, RPN #114 indicated that resident #004 did have the specified intervention in place, which were utilized as a PASD to assist with an activity of daily living. RPN #114 further indicated that if a resident had a PASD in place, the expectation in the home was that the PASD should be listed within the resident's plan of care.

During an interview, the DOC indicated that the expectation in the home was that any PASD in place for a resident should be listed within the resident's plan of care.

The licensee has failed to ensure that the specified intervention which was utilized as a PASD to assist resident #004 with a routine activity of daily living was included in the resident's plan of care. [s. 33. (3)]

2. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist resident #013 with routine activities of daily living had been approved by any person provided for in the regulations.

During Stage I of the RQI, resident #013 was observed on a specified date, by Inspector #672 to have a specified intervention in place. Resident #013 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of the observations made during Stage I, specific to the use of the specified intervention.

During an interview, PSW #121 indicated that resident #013 had a specified intervention in place, which were utilized as a PASD to assist with an activity of daily living.

During an interview, RPN #104 indicated that resident #013 utilized the specified intervention as a PASD. RPN #104 further indicated that resident #013 did not have an order in place for the PASD, as orders were not required in the home when this specified intervention was used as a PASD.

During an interview, the Director of Care (DOC) indicated that orders were required for all PASDs being utilized in the home. The DOC further indicated the no matter who ordered the specified intervention to be utilized as a PASD for resident #013, it should be located under the Physician's Orders, and listed within the current Quarterly Medication Review.

Inspector #672 reviewed the current Physician's Orders for resident #013, and could not locate any orders related to the specified intervention being utilized as a PASD. Inspector #672 then reviewed the current Quarterly Medication Review, and could not locate any orders or directions related to the specified intervention being utilized as a PASD for resident #013.

The licensee failed to ensure that resident #013 had an order in place for use of a PASD under subsection (3), to assist resident #013 with routine activities of daily living. [s. 33. (4) 3.]

3. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist resident #006 with routine activities of daily living had been approved by any person provided for in the regulations.

During Stage I of the RQI, resident #006 was observed on a specified date and time, by Inspector #110 to have a specified intervention in place, which the resident was observed to be utilizing to assist with an activity of daily living. Resident #006 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of the observations made during Stage I, specific to the use of the specified intervention.

During an interview, PSW #111 indicated that resident #006 had a specified intervention in place, which was utilized as a PASD to assist with an activity of daily living.

During an interview, RPN #112 indicated that resident #006 utilized the specified intervention as a PASD. RPN #112 further indicated that resident #006 did not have an order in place for the PASD, as orders were not required in the home this

specific intervention was used as a PASD.

During an interview, the Director of Care (DOC) indicated that orders were required for all PASDs being utilized in the home. The DOC further indicated the no matter who ordered the PASD for the resident, it should be located under the Physician's Orders, and listed within the current Quarterly Medication Review.

Inspector #672 reviewed the current Physician's Orders for resident #006, and could not locate any orders related to the specified intervention being utilized as a PASD. Inspector #672 then reviewed the current Quarterly Medication Review, and could not locate any orders or directions related to the specified intervention being utilized as a PASD for resident #006.

The licensee failed to ensure that resident #006 had an order in place for use of a PASD under subsection (3), to assist resident #006 with routine activities of daily living. [s. 33. (4) 3.]

4. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist resident #004 with a routine activity of daily living had been approved by any person provided for in the regulations.

During Stage I of the RQI, resident #004 was observed on a specified date, by Inspector #110 to have a specified intervention in place. Resident #004 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of the observations made during Stage I, specific to the specified intervention.

During an interview, PSW #115 indicated that resident #004 had a specified intervention in place. PSW #115 further indicated that resident #004 utilized the specified intervention to assist with an activity of daily living.

During an interview, RPN #114 indicated that resident #004 did have a specified intervention in place, which were utilized as a PASD to assist with an activity of daily living. RPN #114 further indicated that resident #004 did not have an order for the PASD to be in place, as orders were not required in the home when this specific intervention was used as a PASD.

During an interview, the Director of Care (DOC) indicated that orders were required for all PASDs being utilized in the home. The DOC further indicated the

no matter who ordered the PASD for the resident, it should be located under the Physician's Orders, and listed within the current Quarterly Medication Review.

Inspector #672 reviewed the current Physician's Orders for resident #004, and could not locate any orders related to the specified intervention being utilized as a PASD. Inspector #672 then reviewed the current Quarterly Medication Review, and could not locate any orders or directions related to the specified intervention being utilized as a PASD for resident #004.

The licensee failed to ensure that resident #004 had an order in place for use of a PASD under subsection (3), to assist resident #004 with a routine activity of daily living. [s. 33. (4) 3.]

5. The licensee has failed to ensure that the use of a PASD under subsection (3) to assist resident #006 with routine activities of daily living had been consented to.

During Stage I of the RQI, resident #006 was observed on a specified date and time, by Inspector #110 to have a specified intervention in place, which the resident was observed to be utilizing to assist with an activity of daily living. Resident #006 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of the observations made during Stage I, specific to the use of the specified intervention.

During an interview, PSW #111 indicated that resident #006 had the specified intervention in place, which was utilized as a PASD to assist with an activity of daily living.

Inspector #672 reviewed resident #006's health care record, and could not locate any signed consents related to utilizing the specified intervention as a PASD.

Inspector #672 reviewed resident #006's written plans of care, and noted that the PASD focus related to the specified intervention was added on a specified date. Inspector #672 then reviewed the progress notes for resident #006, and did not observe any progress notes related to obtaining verbal consent for the use of the specified intervention as a PASD.

During an interview, RPN #112 indicated that resident #006 utilized the specified intervention as a PASD. RPN #112 further indicated that resident #006 did not have any consents in place for the PASD, as consents were not required in the

home when this specified intervention was used as a PASD.

During an interview, the Director of Care (DOC) indicated that consents were required for all PASDs being utilized in the home.

The licensee failed to ensure that resident #006 had consent in place for use of a PASD under subsection (3), to assist resident #006 with a routine activities of daily living. [s. 33. (4) 4.]

6. The licensee has failed to ensure that resident #004 had consent in place for use of a PASD under subsection (3), to assist resident #004 with a routine activity of daily living.

During Stage I of the RQI, resident #004 was observed on a specified date, by Inspector #110 to have a specified intervention in place. Resident #004 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of the observations made during Stage I, specific to the use of the specified intervention.

During an interview, PSW #115 indicated that resident #004 had a specified intervention in place. PSW #115 further indicated that resident #004 utilized the specified intervention to assist with an activity of daily living.

Inspector #672 reviewed resident #004's health care record, and could not locate any signed consents related to utilizing the specified intervention as a PASD.

Inspector #672 then reviewed the progress notes for resident #004 for a specified time period, and did not observe any progress notes related to obtaining verbal consent for the use of the specified intervention as a PASD.

During an interview, RPN #114 indicated that resident #004 did have a specified intervention in place, which were utilized as a PASD to assist with an activity of daily living. RPN #114 further indicated that resident #004 did not have consent for the PASD to be in place, as consents were not required in the home when this specified intervention was used as a PASD.

During an interview, the Director of Care (DOC) indicated that consents were required for all PASDs being utilized in the home.

The licensee failed to ensure that resident #004 had consent in place for use of a PASD under subsection (3), to assist resident #004 with a routine activity of daily living. [s. 33. (4) 4.]

7. The licensee has failed to ensure that resident #013 had consent in place for use of a PASD under subsection (3), to assist resident #013 with routine activities of daily living.

During Stage I of the RQI, resident #013 was observed on a specified date, by Inspector #672 to have a specified intervention in place. Resident #013 triggered through to Stage II of the RQI process, related to Minimizing of Restraining, as a result of the observations made during Stage I, specific to the use of the specified intervention.

During an interview, PSW #121 indicated that resident #013 had a specified intervention in place to assist with an activity of daily living.

Inspector #672 reviewed resident #013's health care record, and could not locate any signed consents related to utilizing the specified intervention as a PASD.

Inspector #672 reviewed resident #013's written plans of care, and noted that the PASD focus related to the specified intervention was added on a specified date. Inspector #672 then reviewed the progress notes for resident #013 for a specified time period, and did not observe any progress note related to obtaining verbal consent for the use of the specified intervention as a PASD for resident #013.

During an interview, RPN #104 indicated that resident #013 utilized the specified intervention as a PASD. RPN #104 further indicated that resident #013 did not have any consents in place for the PASD, as consents were not required in the home when this specified intervention was used as a PASD.

During an interview, the Director of Care (DOC) indicated that consents were required for all PASDs being utilized in the home.

The licensee failed to ensure that resident #013 had consent in place for use of a PASD under subsection (3), to assist resident #013 with routine activities of daily living. [s. 33. (4) 4.]

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 when a PASD is used to assist a resident with a routine activity of living, it is included in the plan of care; the PASD has been approved by a professional as listed within the legislation under s.33(4)3; and the PASD has been consented to by the resident, or if the resident is incapable, a Substitute Decision Maker with authority to provide the consent;, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 37. Personal items and personal aids

Specifically failed to comply with the following:

s. 37. (1) Every licensee of a long-term care home shall ensure that each resident of the home has his or her personal items, including personal aids such as dentures, glasses and hearing aids,
(a) labelled within 48 hours of admission and of acquiring, in the case of new items; and O. Reg. 79/10, s. 37 (1).
(b) cleaned as required. O. Reg. 79/10, s. 37 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring.

During the initial tour of the home, Inspector #672 observed the following:

• In the 3E unit's spa room, there was one roll of deodorant without a resident label, one pink hairbrush and one grey hairbrush with hairs caught in them, both

without a resident label, sitting on the counter.

During an interview, PSW #100 indicated being unsure of which resident the items belonged to. PSW #100 further indicated that all personal items were to be labelled with the resident's name that they belonged to, and used only for that resident.

During the initial tour of the home, Inspector #110 observed the following:

• In the 4W spa room, there was a bar of soap in a container, without a resident label, sitting in the shower area.

On a specified date, Inspector #672 made the following observations during Stage I of the RQI:

• At a specified time, in a specified room, related to resident #011, there were two unlabeled K basins, one unlabeled roll of deodorant which had been used, two unlabeled tubes of opened toothpaste, one unlabeled tube of Fixodent, and one unlabeled urine specimen cup in the bathroom, which was shared between two residents.

• At a specified time, in a specified room, related to resident #012, there were two unlabeled used toothbrushes and one unlabeled hair brush, which had a lot of hairs caught in it, sitting on the counter in the bathroom, which was shared with another resident.

• At a specified time, in a specified room, related to resident #014, there were three unlabeled toothbrushes, and one unlabeled basin in this shared bathroom. All appeared to have been previously used.

• At a specified time, in a specified room, related to resident #020, there were two unlabeled wash basins, two unlabeled tubes of open and used toothpaste, one unlabeled white and blue toothbrush, and one unlabeled urine collector on the back of the toilet, in this shared bathroom.

On a specified date, in the spa room on unit 3E, Inspector #672 noted an unlabelled green hair brush on the counter, with hairs in it.

During an interview, PSW #110 indicated being unable to state who the hairbrush

belonged to, and that the expectation in the home was that all personal items were labelled with the resident's name that it belonged to.

During an interview, ADOC #107 indicated that the expectation in the home was that all personal items were labelled with the resident's name who the item belonged to.

The licensee has failed to ensure that each resident had their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission and in the case of new items, of acquiring. [s. 37. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident has their personal items, including personal aids such as dentures, glasses and hearing aids, labelled within 48 hours of admission, and in the case of new items, of acquiring,, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 43. Every licensee of a long-term care home shall ensure that strategies are developed and implemented to meet the needs of residents with compromised communication and verbalization skills, of residents with cognitive impairment and of residents who cannot communicate in the language or languages used in the home. O. Reg. 79/10, s. 43.

Findings/Faits saillants :

1. The licensee has failed to ensure that strategies were developed and

implemented to meet the needs of residents who could not communicate in the language(s) spoken in the home.

Resident #004 was identified in Stage I of the RQI during their interview for concerns regarding communication with frontline staff and lack of dignity.

Resident #004's plan of care was reviewed and revealed and identified the resident's primary language of communication as a specified language. Interventions were included for staff to implement.

In an interview, resident #004 identified that staff in the home made them feel rushed and disrespected due to a language barrier. The resident identified that staff appeared not to understand that the resident was alert and aware of their surroundings. Further interview with resident #004 and their SDM identified resident #004 felt embarrassed when struggling to communicate with staff for ADL care. Resident #004 and SDM identified the staff would call the SDM when they needed to translate on behalf of resident to frontline staff who provided care. The SDM and resident #004 identified a specified staff member who spoke the resident's language, but did not provide resident care or provide regular translation for frontline staff for ADL care.

Interview with PSW #156 and RPN #114 identified resident #004's primary language, and reported that the resident had difficulty making themselves understood to staff, who did not speak the language. PSW #156 and RPN #114 were unable to identify strategies to promote and enhance resident #004's communication as outlined in their plan of care. Resident #004's written plan of care was reviewed with PSW #156 and RPN #114, and staff reported that an identified staff member who spoke the resident's lanuage would visit the resident and speak to resident #004 for 10 to 20 minutes. Both staff identified that the identified staff member did not provide care or translate to front line staff who provided resident #004 direct care. PSW #156 and RPN #114 were unable to demonstrate resident #004 received a specified intervention to enhance communication of staff with the resident when needed for communication.

Resident and SDM interviews, and staff reports were reviewed with the ADOC along with resident #004's written plan of care. The ADOC reiterated that resident #004's SDM was called when translation of the resident's communication was required. The ADOC was unable to demonstrate how the staff implemented resident #004's communication intervention as noted above. [s. 43.]

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 strategies are developed and implemented to meet the needs of residents who can not communicate in the language(s) spoken in the home,, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004's SDM was immediately notified upon becoming aware of an allegation of abuse of the resident that resulted in physical pain to the resident, and caused distress to the resident that could potentially be detrimental to the resident' s health or well-being.

Resident #004's family member brought forward several areas of concern to Inspector #672, regarding the care administered and the way resident #004 was treated in the home. During record review, Inspector #672 reviewed resident #004's progress notes for a specified period of time. An entry from a specified date, indicated that resident #004 alleged that on a specified date and time, while resident #004 was being assisted to bed by two PSW staff, they caused resident #004 to bang a body part, which caused pain to the specified area for a specified period of time. Resident #004 reported this allegation to a staff member, who immediately reported the allegation to RPN #114, and the DOC.

During an interview, RPN #114 indicated they had not informed resident #004's SDM of the allegation that was brought forward, as the incident had not occurred on their shift. RPN #114 further indicated being aware that management had been notified of the allegation brought forward by resident #004, therefore believed that someone from the management team would have notified resident #004's SDM.

During an interview, ADOC #107 indicated becoming aware of the allegation brought forward by resident #004 after reading about it in the 24hr report. ADOC #107 further indicated being unaware if resident #004's SDM had been made aware of the allegation, as the DOC had conducted most of the investigation into the allegation, and had followed up with the staff.

During an interview, the DOC indicated being unsure if the SDM of resident #004 had been notified of the incident, as that information was not listed within the internal notes created during the investigation into the matter, and there was no supporting documentation in resident #004's progress notes to indicate the SDM had been notified. The DOC further indicated that the expectation in the home was that all communication and notification of resident's SDMs were to be documented within the progress notes for the resident, and if the documentation was not completed, it was considered that the notification had not occurred.

During an interview, resident #004's SDM indicated they had not been notified by any of the staff or management team of the allegation related to resident #004,

which caused resident #004's identified body part to be hit, resulting in pain to the identified body part for a specified period of time.

The licensee has failed to ensure that resident #004's SDM was informed of an allegation of abuse of the resident that resulted in physical pain to the resident, and caused distress to the resident that could potentially be detrimental to the resident' s health or well-being. [s. 97. (1) (a)]

2. The licensee has failed to ensure that resident #004's SDM was notified of the results of internal investigations into two allegations of staff to resident abuse, immediately upon completion.

Resident #004's family member brought forward several areas of concern to Inspector #672, regarding the care administered and the way resident #004 was treated in the home. During record review, Inspector #672 reviewed resident #004's progress notes for a specified period of time. An entry from a specified date, indicated that resident #004 alleged that on a specified date and time, while resident #004 was being assisted to bed by two PSW staff, they caused resident #004 to bang a body part, which caused pain to the specified area for a specified period of time. Resident #004 reported this allegation to a staff member, who immediately reported the allegation to RPN #114, and the DOC.

Further review of resident #004's progress notes indicated that there was an allegation of staff to resident abuse, which had occurred on a specified date, when resident #004 alleged that PSW #120 had exhibited behaviours consistent with the definition of staff to resident abuse.

During an interview, resident #004's SDM indicated being unaware of the outcome of the internal investigation into the incident which occurred on either of the specified dates. Resident #004's SDM further indicated that several incidents had occurred involving resident #004, and multiple complaints had been filed with the home, but no responses or follow up to any of the issues were received by resident #004 or resident #004's SDM, which caused frustration and resentment from resident #004's SDM.

During an interview, ADOC #107 indicated being unaware if resident #004's SDM had been made aware of the outcome of the internal investigation into the allegation from the first incident, as the DOC had conducted most of the investigation into the allegation. ADOC #107 further indicated that at the time of

the interview, resident #004's SDM had not been notified of the results into the internal investigation into the allegation from the second incident.

During an interview, the DOC indicated being unsure if the SDM of resident #004 had been notified of the outcome of the internal investigation, as that information was not listed within the internal notes created during the investigation into the matter, and there was no supporting documentation in resident #004's progress notes to indicate the SDM had been notified. The DOC further indicated being unaware if resident #004's SDM had been notified of the outcome of the internal investigation into the alleged second incident, as the DOC had been away on vacation during that time period, and ADOC #107 had been conducting the investigation into the allegation.

The licensee has failed to ensure the resident #004's SDM was notified of the outcome into the internal investigations into two alleged incidents of staff to resident abuse. [s. 97. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all SDMs are immediately notified of all allegations of abuse of the resident, along with the results of the internal investigations into the allegation of abuse, immediately upon completion,, to be implemented voluntarily.

WN #12: 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).

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a response to every complaint which was brought forward was provided to the complainant within 10 business days of receipt of the complaint.

Resident #004 triggered through to Stage II of the RQI. Inspector #672 interviewed resident #004's family member, who brought forward several areas of

concern, and indicated frustration at the lack of response, follow up, or changes made in relation to the complaints brought forward.

During an interview, resident #004's SDM/family member indicated feeling frustrated with the management team and the complaints process implemented in the home, as they did not feel that there was truly a process in place to deal with complaints brought forward from residents or family members. Resident #004's family member further indicated that multiple complaints had been brought forward to the registered staff and/or management team during a specified period of time, related to the care of resident #004, but they had not been provided with any follow up or responses to the complaints. Resident #004's family member indicated that once an issue was brought forward to the licensee, there usually would be no further communication regarding the complaint, unless the complainant approached the management team directly to follow up, and/or request information. The family member further indicated that when the management team was approached to request information, no exact action plans were ever provided regarding any of the complaints which were brought forward, instead they were provided with statements such as "we're working on it". Resident #004's family member indicated this fostered feelings of frustration with resident #004 and the resident's entire extended family. The complainant further indicated belief that complaints could be brought forward in the home either verbally or by writing a letter to the management team, but that there were no complaint forms available for residents or family members to document any areas of concern or complaint. The family member indicated that a written complaint had most recently been provided to the DOC on a specified date, and verbal complaints had been submitted up to the middle of a specified month, but no responses had been received to the complaints made.

During an interview, ADOC #107 indicated that multiple complaints had been received from resident #004 and/or resident #004's family during a specified period of time, and believed complaints had been received during another specified time period. ADOC #107 further indicated being unaware if responses had been provided to the complainant regarding all of the complaints which had been brought forward, and was unable to find any documentation of the complaints brought forward, the resolutions (if any), or the responses provided.

During an interview, the DOC indicated being aware of multiple complaints brought forward by resident #004 and/or resident #004's family during a specified period of time, most recently receiving a written complaint from the family of

resident #004 on a specified date. The DOC further indicated being unaware if a formal response had been provided to each of resident #004 and/or resident #004's family member's complaints, and was unable to find any documentation of the complaints brought forward, the resolutions (if any), or the responses provided, other than to the written complaint which had been received on a specified date. The DOC indicated that the period of 10 business days for complaints to be resolved were not being followed in the home, due to complaints not being added to the internal complaints log, and not having a procedure in place which allowed managers to ensure all complaints were being brought forward, followed up on, or to be tracked. The DOC indicated that during a specified time period, the management team had held a meeting to discuss the Complaints and Customer Service internal policy, and what was required to ensure that the requirements and legislation were being met, but the internal policy or interventions discussed during the meeting had not yet been implemented, due to workload issues.

During an interview, the ED indicated that there were no practices in the home which allowed for complaints to be followed up on or tracked to ensure that they were being completed within the expected time frames, or to ensure that all complaints received were added to the formal internal complaints log. The ED further indicated that it was "likely" that there were currently complaints being brought forward in the home by residents, family members, or visitors, which were not being followed up on or were being forgotten.

The licensee failed to ensure that a response to every complaint brought forward by resident #004 and/or resident #004's family members were provided to the complainant within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

2. The licensee has failed to ensure that a documented record was kept in the home of all complaints received.

Resident #004 triggered through to Stage II of the RQI. Inspector #672 interviewed resident #004's family member, who brought forward several areas of concern, and indicated frustration at the lack of response, follow up, or changes made in relation to the complaints brought forward.

During an interview, resident #004's SDM/family member indicated feeling frustrated with the management team and the complaints process implemented in the home, as they did not feel that there was truly a process in place to deal with

complaints brought forward from residents or family members. Resident #004's family member further indicated that multiple complaints had been brought forward to the registered staff and/or management team during a specified period of time, related to the care of resident #004, but they had not been provided with any follow up or responses to the complaints. Resident #004's family member indicated that once an issue was brought forward to the licensee, there usually would be no further communication regarding the complaint, unless the complainant approached the management team directly to follow up, and/or request information. The family member further indicated that when the management team was approached to request information, no exact action plans were ever provided regarding any of the complaints which were brought forward, instead they were provided with statements such as "we're working on it". Resident #004's family member indicated this fostered feelings of frustration with resident #004 and the resident's entire extended family. The complainant further indicated belief that complaints could be brought forward in the home either verbally or by writing a letter to the management team, but that there were no complaint forms available for residents or family members to document any areas of concern or complaint. The family member indicated that a written complaint had most recently been provided to the DOC on a specified date, and verbal complaints had been submitted up to the middle of a specified month, but no responses had been received to the complaints made.

On a specified date, Inspector #672 requested to review the licensee's internal complaints log for two specified years. Review of the oldest complaints log indicated that seven complaints had been added to the log during that year, none of which were related to resident #004. One of the complaints listed in the log was missing documentation regarding any responses made by the complainant. The six other complaints listed were missing documentation related to the nature of each complaint, the dates the complaints were received, any time frames for actions to be taken, any follow up actions required, what the final resolution of the complaints were (if any), the date(s) on which any response was provided to the complainant along with a description of the response, or any responses made in turn by the complainant. All seven complaints listed in the complaints log for the first year appeared to have been received between a specified three month time period, and there was no documentation for the other three quarters.

There was no information added to the complaints log for the second specified year at all, as of a specified date.

During an interview, ADOC #107 indicated that multiple complaints had been received from resident #004 and/or resident #004's family in 2018, and believed complaints had also been received during a specified time period. ADOC #107 further indicated that complaints which were received were brought forward at the morning managers meeting, and the DOC or the ED were responsible for adding the complaints to the internal complaints log.

During an interview, the DOC indicated being aware of multiple complaints brought forward by resident #004 and/or resident #004's family during a specified time period, most recently receiving a written complaint from the family of resident #004 on a specified date, which had not been added to the internal complaints log. The DOC further indicated that the home did not have a procedure in place which allowed managers to ensure that all complaints received were being brought forward to the managers meeting, or for the complaints to be tracked, to ensure proper responses were provided to the complainant and documented. The DOC indicated that during a specified time period, the management team had held a meeting to discuss the Complaints and Customer Service internal policy, and what was required to ensure that the requirements and legislation were being met, but the internal policy and interventions discussed during the meeting had not been implemented, due to workload issues.

During an interview, the ED indicated that complaints were not being added to the internal complaints log regularly, and no complaints had yet been added for a specified time period, although multiple complaints had been received. The ED further indicated that there were no practices in the home which allowed for complaints to be followed up on or tracked to ensure that they were being completed within the expected time frames, or to ensure that all complaints received were added to the formal internal complaints log, with all of the required information. The ED further indicated that it was "likely" that there were currently complaints being brought forward in the home by residents, family members, or visitors, which were not being followed up on or were being forgotten.

The licensee failed to ensure that a documented record was kept in the home of all complaints received during a specified time period, which included all of the required documentation under O. Reg. 79/10, s. 101 (2). [s. 101. (2)]

3. The licensee has failed to ensure that a documented record of complaints received were reviewed and analyzed for trends, at least quarterly, and a written record was kept of each review, along with the improvements made in response.

On a specified date, Inspector #672 requested to review the internal complaints log for two specified years, as a result of complaint(s) brought forward during the RQI process. Review of the complaints log for the first year indicated that seven complaints had been added to the log during that year. All seven complaints listed in the complaints log appeared to have been received between a specified three month time period, and there was no documentation for the other three quarters.

There was no information added to the complaints log for the second year at all, as of a specified date.

During an interview, ADOC #107 indicated that multiple complaints had been received from resident #004 and/or resident #004's family during a specified time period, and believed complaints had been received during another specified time period. ADOC #107 further indicated that complaints which were received were brought forward at the morning managers meeting, and the DOC or the ED were responsible for adding the received complaint to the internal complaints log, and completing the quarterly review of the complaints received.

During an interview, the DOC indicated being aware of multiple complaints brought forward by resident #004 and/or resident #004's family during a specified time period, most recently receiving a written complaint from the family of resident #004 on a specified date, which had not been added to the internal complaints log. The DOC further indicated that it was the responsibility of the ED to review/analyze the complaints workbook for trends, and continuous quality improvement.

During an interview, the ED indicated that complaints were not being added to the internal complaints log regularly, and no complaints had yet been added for a specified time period, although multiple complaints had been received. The ED further indicated that the internal complaints logs were not being completed or reviewed/analyzed for trends on a quarterly basis, for the purposes of continuous quality improvement, or any other reasons.

The licensee has failed to ensure that a documented record of complaints received were reviewed and analyzed for trends, at least quarterly, and a written record was kept of each review and of the improvements made in response. [s. 101. (3)]

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 every written or verbal complaint that the licensee is aware of shall be investigated within 10 business days and resolved where possible, and a response that complies with paragraph 3 is provided within 10 business days to the complainant; to ensure that a documented record is kept in the home which includes all required information, as outlined in the legislation; and to ensure that the documented record is reviewed and analyzed for trends at least quarterly,, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that every medication incident involving a resident and every adverse drug reaction had been reported to the resident's Substitute Decision-Maker (SDM).

As part of the RQI, three high risk medication incidents and adverse drug reactions from the past quarter that had been analyzed and evaluated in the home's most recent Professional Advisory Committee Meeting dated a specified date, had been reviewed.

A review of the home's medication incidents from a specified three month time period, did not identify any documentation on the medication incident forms and progress notes that the SDM had been notified of the following medication incidents:

Resident #034 – On a specified date, it was discovered that the resident did not receive their identified medication at the specified time. There was no information obtained to indicate that the SDM had been notified.

Resident #035 – On a specified date, it was discovered that the resident did not receive their two identified medications at the specified time. There was no information obtained to indicate that the SDM had been notified.

Resident #038 – On a specified date, it was discovered that the resident did not receive their six identified medications on a specified date and time. There was no information obtained to indicate that the SDM had been notified.

An interview with RPN #104 stated that when a medication incident occurred, the registered staff who discovered the error would take the resident's vital signs, assess, and monitor the resident. The RPN further indicated that they would notify the physician, the resident if they are cognitively intact, and the resident's SDM. Fill out the medication incident form online, which gets sent automatically to pharmacy and the DOC. Documentation of the incident including actions taken, and individuals that had been notified, would be completed on the medication incident form and progress notes. When asked by the inspector whether RPN #104 had informed the residents' SDMs of the above mentioned medication incidents, the RPN was unable to confirm they had informed the SDM of the incident as they could not show the inspector evidence of documentation that they had informed the SDM.

During an interview, the inspector and the DOC reviewed the above mentioned medication incident reports. The DOC stated that the home's expectation was for the registered staff to notify the SDM of the above mentioned medication

incidents, and document the notification on the medication incident form. [s. 135. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that every medication incident involving a resident and every adverse drug reaction is reported to the resident's Substitute Decision-Maker (SDM), to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participate in the implementation of the licensee's infection prevention and control program.

On a specified date and time, Inspector #672 observed the afternoon nourishment pass on a specified resident home area, which was being completed by PSW #101. No hand hygiene was observed being completed by PSW #101, while the PSW was entering and exiting resident rooms to deliver food and fluids, and removing dirty dishes.

During an interview, PSW #101 indicated that the expectation in the home was that hand hygiene was to be completed upon entering and exiting each resident room, and between serving each resident.

On a specified date and time, Inspector #672 observed the nourishment cart on an identified resident home area. Three PSWs were observed to be assisting with completing the nourishment cart, and none of them were observed to be completing hand hygiene between residents. PSW #117 was observed to be assisting a resident with the nourishment while they were resting in bed, and no hand hygiene was completed before or afterward entering the resident's room to assist.

During an interview, PSW #117 indicated that the expectation in the home was to wash hands at the beginning of the nourishment pass, which the PSW indicated had been done.

During an interview, PSW #118 indicated the expectation in the home was that hand hygiene was to be completed prior to and after assisting each resident, and after emptying a resident's cup after use.

During an interview, PSW #119, indicated hand hygiene was required after feeding or helping a resident.

On a specified date and time, Inspector #672 observed a specified nourishment pass on an identified resident home area, and noted that the PSWs completing the nourishment pass were not always completing hand hygiene between each resident, including when dirty dishes were removed from resident's rooms.

During an interview, PSW #129 indicated that the expectation in the home was that hands were washed between assisting each resident, while completing the nourishment passes.

During an interview, the DOC indicated that the expectation in the home was that hand hygiene was to be completed between assisting each resident, while completing the nourishment pass. [s. 229. (4)]

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 all staff participate in the implementation of the licensee's infection prevention and control program, specific to hand hygiene during the nourishment passes,, to be implemented voluntarily.

WN #15: 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).
2. Every resident has the right to be protected from abuse. 2007, c. 8, s. 3 (1).
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).
5. Every resident has the right to live in a safe and clean environment. 2007, c. 8, s. 3 (1).
6. Every resident has the right to exercise the rights of a citizen. 2007, c. 8, s. 3 (1).
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents. 2007, c. 8, s. 3 (1).
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).

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible. 2007, c. 8, s. 3 (1).

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act. 2007, c. 8, s. 3 (1).

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference. 2007, c. 8, s. 3 (1).

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day. 2007, c. 8, s. 3 (1).

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately. 2007, c. 8, s. 3 (1).

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home. 2007, c. 8, s. 3 (1).
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home. 2007, c. 8, s. 3 (1).
19. Every resident has the right to have his or her lifestyle and choices respected. 2007, c. 8, s. 3 (1).
20. Every resident has the right to participate in the Residents' Council. 2007, c. 8, s. 3 (1).
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy. 2007, c. 8, s. 3 (1).
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available. 2007, c. 8, s. 3 (1).
23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential. 2007, c. 8, s. 3 (1).
24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints. 2007, c. 8, s. 3 (1).
25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so. 2007, c. 8, s. 3 (1).
26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible. 2007, c. 8, s. 3 (1).
27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's personal health information within the meaning of the 'Personal Health Information Protection Act, 2004' was kept confidential, in accordance with that Act.

During the initial tour of the home at an identified time, Inspector #672 observed the following:

• In an identified area for residents, families, and volunteers, Inspector #672 noted

a large stack of documents, which had resident information in them, such as diet/textures/allergies/room numbers, etc sitting in an open and accessible area. The first pile of papers was entitled "Snack Service Report", and the second was a "Pain/Palliative FICA Assessment" for an identified resident. There were three residents and two visitors sitting in the kitchen area at the time, along with numerous residents, staff, volunteers and visitors walking by the area, as the elevators to the home were located directly across from the area. Inspector #672 brought the piles of confidential paperwork to the receptionist at the front desk. The following day, there was a note posted, which indicated that the paperwork was being stored in a locked drawer in an identified area.

On a specified date and time, Inspector #672 made the following observation:

• On an identified resident home area, Inspector #672 observed a cart in the northwest hallway, which had an open binder and book sitting on the top. Within the binder were full resident lists, which included full first and last name, and room number. One of the resident lists also included the type of bed rails utilized by the resident, along with interventions in place for the resident, such as alarms, floor mats, type of bed, etc. After approximately eight minutes, PSW#155 approached the cart, indicating responsibility for it. PSW #155 further indicated the expectation in the home was that resident's personal information was to remain confidential at all times, by ensuring it was properly stored so that others could not access it.

On a specified date and time, Inspector #672 made the following observation:

• The door to the hair salon on the main floor was left wide open, with no staff in the immediate area. There were multiple residents in the area, either walking by the salon, or sitting in the area. Within the salon was a complete resident list sitting on the counter, which included the resident's full name and room number. After waiting for a specified period of time for a staff member to return, Inspector #672 reported to the receptionist that the door was left open, with no staff members noted to be in the area. The receptionist indicated that the door to the salon was left open, as it was supposed to be receiving a "deep clean". No housekeeping or maintenance staff were observed to be in the immediate area, and no cleaning equipment was observed.

During an interview, the ED indicated that the expectation in the home was that all resident's personal information/personal health information was to be stored in a secured manner at all times, which could only be accessed by the staff members

who required the information.

The licensee has failed to ensure that every resident's personal health information within the meaning of the 'Personal Health Information Protection Act, 2004' was kept confidential, in accordance with that Act. [s. 3. (1)]

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all written complaints concerning the care of resident #004 received were immediately forwarded to the Director.

Resident #004 triggered through to Stage II of the RQI. Inspector #672 interviewed resident #004's SDM, who brought forward several areas of concern, and indicated frustration at the lack of response, follow up, or changes made in relation to the complaints brought forward.

During an interview, resident #004's SDM indicated that several complaints had been submitted to the management team of the home during a specified period of time, most recently that a written complaint had been provided to the DOC on a specified date.

Inspector #672 reviewed the written complaint submitted by the family of resident #004 on the specified date, which outlined concerns related to what the family perceived as repeating occurrences which placed resident #004 in jeopardy. The written complaint indicated the family members were disappointed that the

situation continued to occur. The written complaint indicated that resident #004 still had concerns. The written complaint went on to indicate that immediate action on the part of the management team, to stop the situation that was causing the family concern.

During an interview, the DOC indicated that a written complaint had been received by the family of resident #004, which had not been forwarded to the Director. The DOC stated the complaint had not been forwarded to the Director due to the fact that the complaint was received via email, instead of being post or hand delivered. The DOC further indicated being aware that the home's internal policy indicated that emailed complaints were to be considered written complaints, and that the intent of the complaint received had not been clarified with resident #004's family member. The DOC indicated that the complaint should have been submitted to the Director immediately upon receipt, as the complaint was related to the care resident #004 was being provided, and areas of concern regarding resident #004's safety.

During an interview, the ED indicated that emailed complaints were to be considered written complaints, and all written complaints were to be immediately forwarded to the Director.

The licensee failed to ensure that a written complaint received from the family of resident #004, which concerned the care and safety of resident #004, was forwarded to the Director. [s. 22. (1)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 111. Requirements relating to the use of a PASD

Specifically failed to comply with the following:

s. 111. (1) Every licensee of a long-term care home shall ensure that a PASD used under section 33 of the Act to assist a resident with a routine activity of living is removed as soon as it is no longer required to provide such assistance, unless the resident requests that it be retained. O. Reg. 79/10, s. 111. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the PASD used to assist resident #013 with routine activities of daily living was removed as soon as it was no longer required to provide such assistance.

During Stage I of the RQI, resident #013 was observed on a specified date, by Inspector #672 to have an identified intervention in place. Resident #013 triggered through to Stage II of the RQI process, as a result of the observations made during Stage I, specific to the use of the identified intervention.

During an interview, PSW #121 indicated that resident #013 had an identified intervention in place, which was utilized as a PASD for the purposes of an activity of daily living. PSW #121 further indicated that when resident #013 was approached at specified times of the day, the identified intervention was in the engaged position.

During an interview, RPN #104 indicated that resident #013 utilized the identified intervention as a PASD.

During an interview, PSW #151 indicated that when resident #013 was assisted at a specified time, the identified intervention was put into the engaged position. PSW #151 further indicated that the identified intervention was put into the engaged position in an attempt to prevent resident #013 from falling, as resident #013 was considered at high risk for falls.

Inspector #672 reviewed resident #013's written plans of care, and noted that the PASD focus related to the identified intervention indicated that the PASD was used to assist the resident to complete an activity of daily living, and when that specific activity was completed, the PASD must be removed.

During an interview, the DOC indicated that the expectation in the home was that

PASDs were removed when not being utilized by the resident or staff assisting the resident. The DOC further indicated that the expectation in the home was that the resident's written plan of care was followed at all times, and if changes to the written plan of care were required, this would be reported to the charge nurse on the floor, who would make the required changes.

The licensee has failed to ensure that the identified intervention used as a PASD to assist resident #013 with routine activities of daily living was removed as soon as it was no longer required to provide such assistance. [s. 111. (1)]

Issued on this 7 th day of February, 2019 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JENNIFER BATTEN (672) - (A1)
Inspection No. / No de l'inspection :	2018_578672_0008 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	005359-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Feb 07, 2019(A1)
Licensee / Titulaire de permis :	Southlake Residential Care Village 596 Davis Drive, NEWMARKET, ON, L3Y-2P9
LTC Home / Foyer de SLD :	Southlake Residential Care Village 640 Grace Street, NEWMARKET, ON, L3Y-2P6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Anne Deelstra-McNamara

To Southlake Residential Care Village, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident;
(b) the goals the care is intended to achieve; and
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Order / Ordre :

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

Specifically, the licensee shall ensure the following:

1. Review both written plans of care for residents #023 and #031 to ensure the written plans of care provide clear directions to staff and others who provide direct to the residents related to altered skin integrity for resident #023 and interventions related to falls for resident #031.

2. The written plans of care must be reviewed with all direct care staff who provide care to residents #023 and #031.

3. Keep a documented record of the care plan review and communications with staff.

Grounds / Motifs :

1. The licensee has failed to ensure that the written plan of care set out clear directions to staff and others who provided direct care to resident #031.

Resident #031 was admitted to the home on a specified date, with specified medical diagnosis. Resident #031 also had skin integrity concerns, which the physician was

aware of, and had a specified treatment ordered for the area.

Inspector #672 reviewed the current written plan of care for resident #031, which had a focus specific to the specified area of altered skin integrity. There were interventions listed for the staff to implement, along with weekly skin assessments.

Inspector #672 reviewed the progress notes for resident #031 for a specified time period, which revealed that the area of altered skin integrity was first noted on a specified date. On a later date, the area was noted to have healed, and on a specified date, the treatment to the area and weekly skin assessments were discontinued.

During an interview, PSW #141 indicated that the skin integrity concern related to resident #031 had healed, and staff had no longer been applying the treatments to the area. PSW #141 further indicated that the registered staff were aware that the area had healed, as was the physician, which led to the treatment being discontinued.

During an interview, RPN #103 indicated that resident #031 only had an identified skin integrity concern, as the area of altered skin integrity had healed several months previously. RPN #103 further indicated that the expectation in the home was that the resident's written plan of care be kept current and up to date.

During an interview, the Wound Care Champion, RN #131, indicated the expectation in the home was that written plans of care were kept current, and listed information such as the first date a resident was noted to have any skin integrity issue, along with the location, treatment, and interventions implemented. Once an area was healed, it should either be removed from the written plan of care altogether, or revised to indicate the resident had a 'history of' the skin integrity concern.

During an interview, the DOC indicated that the expectation in the home was that the registered staff on the units were in charge of ensuring the resident's written plans of care were kept current and up to date, which were to reflect any current skin integrity issues, the goals for the area, and the interventions being implemented.

The licensee failed to ensure that the plan of care set out clear directions to staff who provided direct care to resident #031, related to skin integrity concerns which had

been resolved at a specified time, but still appeared as active on the current written plan of care. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #023's written plan of care set out clear directions to staff who provided direct care to the resident.

Related to Log#029263-17:

A Critical Incident Report (CIR) was submitted to the Director, related to a fall sustained by resident #023 on a specified date, which resulted in an injury. At the time of the fall, resident #023 also had another injury present, due to a previous fall. According to the CIR, resident #023 had sustained a specified number of falls during a specified time period. The CIR further stated that resident #023 exhibited identified behaviours, therefore staff were to remain with the resident, while the resident was being assisted with toileting.

Inspector #672 reviewed the progress notes for resident #023 during a specified time period. The progress notes indicated that resident #023 sustained a specified number of falls during that time period.

During an interview, ADOC #107 indicated that instructions had been provided to the registered staff on resident #023's home area to ensure the written plan of care was reviewed and revised following a specified fall, to include a specified intervention.

During separate interviews, PSW #154 and RPN #152 indicated that resident #023 had specified falls prevention interventions in place. RPN #152 further indicated that resident #023 required an identified mobility device for mobility purposes, and a specified level of assistance with transfers, due to specified physical conditions.

Inspector #672 reviewed the written plan of care for resident #023 in place following the fall listed in the CIR submitted to the Director. The written plan of care did not indicate two specific interventions, resident #023's identified risk for falls, the number of falls sustained within a specified time period, nor identified behaviours. The written plan of care did state that resident #023 utilized an identified mobility device (which was different than the mobility device staff indicated the resident utilized), and required a specified level of staff assistance. The written plan of care further indicated that an identified mobility device was only to be utilized during a specified

time, therefore staff were to ensure a specified intervention was in place prior to utilizing the mobility device, and that frontline staff were to report to registered staff any change in resident #023's ability to use the identified mobility device.

The licensee failed to ensure that the written plan of care for resident #023 provided clear direction to staff who provided direct care to the resident, specific to fall prevention interventions. [s. 6. (1) (c)]

The severity of this issue was determined to be a level 3, as there was actual harm/potential for actual harm to residents. The scope of the issue was determined to be a level 1, as this issue was found in two of the residents who were inspected upon during this inspection. The home had a level 4 compliance history, as a VPC was issued during the following inspections, under LTCHA, 2007, s.6 (1) (c):
Resident Quality Inspection (#2016_486653_0010), on October 6, 2016
Resident Quality Inspection (#2017_462600_0019), on November 8, 2017 (672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:

1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,

i. kept closed and locked,

ii.equipped with a door access control system that is kept on at all times, and

iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,

A. is connected to the resident-staff communication and response system, or

B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.

1.1. All doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, must be equipped with locks to restrict unsupervised access to those areas by residents.

2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.

4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Order / Ordre :

The licensee must be compliant with r. 9 (1) of the LTCHA.

Specifically, the licensee shall ensure the following:

1) Prepare, submit and implement a plan to ensure that all doors leading to non-residential areas are kept closed and locked at all times when not being supervised by staff.

2) The plan must include time lines and person(s) responsible for completing the tasks.

3) Educate all staff who work in the home on the plan(s) developed and implemented.

4) Keep a documented record of all plans developed and implemented, and of education provided to the staff.

The plan is to be submitted to the CESAO within 10 business days, to the email address of CentralEastSAO.MOH@ontario.ca, attention Inspector #672, Jennifer Batten.

Grounds / Motifs :

1. The licensee has failed to ensure that all doors leading to non-residential areas were locked when they were not being supervised by staff.

During the initial tour of the home, Inspector #672 made the following observations:

• On an identified resident home area, the door to the storage room in the north hall could be pushed open. There were Oxivir wipes, Personal Protective Equipment (PPE), and other supplies stored within the room. There were no staff observed to be in the immediate area.

RPN #109 confirmed that the door to the storage room was not locked, and could be opened, at a specified time.

• On an identified resident home area, the door to the nursing station was left open, with no staff observed to be in the immediate area, and several residents sitting in

the lounge area just outside the staff room. Resident's confidential charts and oxygen supplies were stored within the room.

On a specified date, Inspector #672 made the following observations at a specified time:

• On an identified resident home area, the door to the nursing station was observed to be left open, with no staff members present, and three residents sitting in the immediate area. Resident's confidential charts and other supplies were stored within the room.

On a specified date, Inspector #672 made the following observations:

• On two identified resident home areas, the doors to the nursing station were observed to be left open, with no staff members present. Resident's confidential charts, a specimen fridge, and other supplies were stored within the room.

• On an identified resident home area, the door to the storage room in the north hall could be pushed open. There were Oxivir wipes, PPE equipment, and other supplies stored within the room.

On a specified date and time, Inspector #672 made the following observation:

• On an identified resident home area, the door to the nursing station was observed to be left open, with no staff members present, and several residents sitting in, and/or walking past the immediate area, on their way to the dining room for lunch. Resident's confidential charts, and other supplies were stored within the room.

During separate interviews, PSW #111, and RPNs #102, #104, and #109, and the Executive Director (ED) indicated that the nursing stations were non-residential areas, and the expectation in the home was that the door was to be kept closed and locked when staff were not in the immediate area.

During separate interviews, RPN #109 and the ED indicated that all storage rooms in the home were considered to be non-residential areas, and the doors should be kept closed and locked at all times, unless there was a staff member removing an item from the storage room.

On a specified date and time, Inspector #672 made the following observation:

• The door to an identified area was left wide open, with no staff in the immediate area. There were multiple residents in the area, either walking by the room, or sitting in the area. Within the identified area were multiple bottles of chemicals, such as "Barbicide", "Cool Mist Astringent", Isopropyl Rubbing Alcohol, multiple bottles of "Neutralisant" hair chemical, hair dyes and solutions. There was also a complete resident list sitting on the counter, which included the resident's full name and room number. After waiting for a specified period of time for a staff member to return, Inspector #672 reported to the receptionist that the door was left open, with no staff members noted to be in the area. The receptionist indicated that the door to the salon was left open, as it was supposed to be receiving a "deep clean". No housekeeping or maintenance staff were observed to be in the immediate area, and no cleaning equipment was observed.

During an interview, the DOC indicated that the expectation in the home was that all doors leading to non-residential areas were kept closed and locked at all times, when staff were not in the immediate area, and that the hair salon was considered to be a non-residential area when staff were not present.

The licensee has failed to ensure that all doors to non-residential areas were kept closed and locked when they were not being supervised by staff.

The severity of this issue was determined to be a level 2, as there was the potential for actual harm/risk to residents, related to all doors leading to non-residential areas not being kept locked when they were not being supervised by staff. The scope of the issue was determined to be a level 2, as there was a pattern of all doors leading to non-residential areas not being kept locked when they were not being supervised by staff. The home had a level 2 compliance history, as there had been previous unrelated non-compliances within the previous 36 months.

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019(A1)

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. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with r. 51 (2) of the LTCHA.

Specifically, the licensee shall ensure the following:

1) Prepare, submit and implement a plan to ensure that residents #022, #006, #021, and every resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions. Where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for the assessment of incontinence.

2) The plan must also include measures to ensure that a range of continence care products are available and that each resident is provided with a product that is based on the resident's individualized assessed needs.

3) Educate all front line staff (PSWs, RPNs, RNs) on the plan(s) developed and implemented.

4) Keep a documented record of all plans developed and implemented, and education provided to the staff.

5) The plan is to be submitted to the CESAO within 10 business days, to the email address of CentralEastSAO.MOH@ontario.ca, attention Inspector #672, Jennifer Batten.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, using a clinically appropriate assessment instrument that was specifically designed for assessment of incontinence.

Inspector #110 reviewed the MDS quarterly review assessment for resident #022, which identified the resident as exhibiting a specified level of continence. The prior

MDS assessment identified the resident as exhibiting a different level of continence. This change would be considered a continence decline.

During separate interviews, RPN #112 and RN #144 confirmed to Inspector #110 that a specified change in a resident's continence level would be considered a deterioration in the resident's continence status. RN #144 further confirmed that the registered staff were to complete a continence assessment when an assessed decline in continence status was identified in the resident at a minimum of quarterly. RN #144 confirmed there was no continence assessment completed as expected for resident #022, related to the assessed decline identified in the identified MDS assessment.

During an interview with Inspector #110, ADOC #106 indicated being the lead for the continence program in the home. ADOC #106 further confirmed that registered staff had not completed a continence assessment as required for resident #022, who experienced a deterioration in their continence level. [s. 51. (2) (a)]

2. Resident #006 triggered during Stage 1 of the RQI, related to their identified risk for incontinence, while exhibiting a specified level of continence, according to the most recent assessment.

Inspector #110 reviewed resident #006's MDS quarterly review assessment, which identified resident #006 as exhibiting a specified level of continence. The prior MDS assessment identified the resident as exhibiting a different level of continence. This change would be considered a continence decline.

During separate interviews with Inspector #110, PSWs #142 and #111 did not confirm a decline of resident #006's continence over this identified time period.

During an interview, RPN #143 revealed to Inspector #110 that when a decline in a resident's continence status was identified during the MDS assessment, the registered staff would complete a continence assessment for the resident. RPN #143 confirmed that resident #006 was identified to exhibit a continence decline in an identified MDS assessment, but there was no corresponding continence assessment completed as expected.

During an interview with Inspector #110, RPN #112 identified in the Point Of Care

documentation, that the PSW documentation for an identified MDS assessment should have indicated the resident exhibited specified levels of continence, and confirmed a decline in resident #006's continence. RPN #112 further indicated that the expectation in the home was that a continence assessment was required to be completed quarterly, and with any deterioration identified in a resident's continence level. RPN #112 indicated that a continence assessment had not been completed for resident #006, as required.

During the record review, Inspector #110 reviewed the licensee's continence policy, entitled "Continence Management Program"; RC-14-01-01; dated February 2017; which identified the following:
"1. Complete a Continence Assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. An assessment is completed:
b. With any deterioration in continence level and
c. At required jurisdictional frequency".

During an interview, ADOC #106 indicated being the lead for the continence care program in the home. ADOC #106 further confirmed that registered staff had not completed a continence assessment as required for resident #006, who experienced a deterioration in their continence level. [s. 51. (2) (a)]

3. Resident #021 triggered during stage 1 of the RQI, related to being identified as a specified risk for incontinence while exhibiting a specified level of continence, according to the most recent assessment.

During the record review, Inspector #110 reviewed the MDS quarterly assessment, which identified resident #021 as exhibiting a specified level of continence. The prior MDS assessment identified the resident as exhibiting a different level of continence. This change would be considered an improvement in the resident's continence level.

Inspector #110 reviewed the PSW documentation specific to a specified look back period MDS assessment, which identified that resident #021 exhibited a specified level of continence.

During separate interviews with Inspector #110, PSWs #153 and #111 indicated that resident #021 exhibited a specified level of continence, and no change or

improvement in their continence level had occurred.

During an interview with Inspector #110, RPN #112 indicated the MDS documentation for a specified time period, was incorrect, and resident #021 exhibited a specified level of continence, not the level of continence as identified in the MDS assessment. RPN #112 further indicated that resident #021 should have had a continence assessment completed as part of the quarterly MDS review during a specified time period, and identified that a continence assessment had not been completed for this resident since a specified time.

During the record review, Inspector #110 reviewed the licensee's continence policy entitled "Continence Management Program"; RC-14-01-01; dated February 2017, which identified the following:
"1. Complete a Continence Assessment using a clinically appropriate assessment tool that is specifically designed for assessing continence. An assessment is completed:
b. With any deterioration in continence level and
c. At required jurisdictional frequency".

During an interview, ADOC #106 indicated being the lead for the continence care program in the home. ADOC #106 further confirmed that registered staff had not completed a continence assessment as required for resident #021, who experienced a deterioration in their continence level. [s. 51. (2) (a)]

4. The licensee has failed to ensure that residents were provided with a range of continence care products, based on their individual assessed needs.

Resident #022 triggered in Stage 1 of the RQI, related to the resident's identified risk for incontinence, while exhibiting a specified level of continence, according to the most recent assessment.

During an interview with Inspector #110, resident #022 identified they required a specified level of assistance with toileting, and wore a specified continence product, due to an identified reason. Resident #022 told Inspector #110 that they gave money to their family member, who bought the identified continence product, which created a significant financial hardship for the resident. Inspector #110 observed a package of the identified continence products in resident #022's closet.

During an interview with Inspector #110, PSW #145 identified that resident #022 usually exhibited an identified level of continence, and wore a specified continence product, for specified reasons. PSW #145 further identified that resident #022's family paid for the specified continence product, and the specified continence products were not available as part of the range of continence care products in the home.

During an interview with Inspector #110, PSW #146 identified that resident #022 preferred to wear the specified continence product, for a specified reason.

Inspector #110 reviewed resident #022's plan of care, which identified that resident #022 wore the specified continence product, which were provided by the family.

Inspector #110 reviewed the "Resident Product List" for resident #022's resident home area, which identified resident #022 required the specified continence product during the day, evening, and night shifts. A further review of the "Resident Product List" for for resident #022's resident home area, identified residents #026 and #027 required the specified continence products as part of their continence care needs.

During separate interviews with Inspector #110, residents #026 and #027 confirmed they also independently purchased their specified continence products.

During an interview with Inspector #110, RPN #147 indicated that the 'Resident Product List' was based on the resident's assessed needs, and confirmed that the specified continence products were required by residents #022, #026 and #027, during the day, evening, and night shifts. RPN #147 further indicated that the home did not provide the specified continence products as part of the continence care products available to the residents in the home, therefore the residents or their families were required to pay for the specified continence products.

During an interview with Inspector #110, ADOC #106 confirmed that the 'Resident Product List' regarding continence care products was based on the resident's assessed needs. ADOC #106 further identified that families were required to pay for the specified continence products, and that the specified continence products were not available in the home, as part of the range of continence care products. ADOC #106 confirmed that there were currently an identified number of residents in the

home who required the specified continence products, who were paying for the products independently, due to the products not being provided by or paid for by the home. [s. 51. (2) (h) (i)]

The severity of this issue was determined to be a level 2, as there was the potential for actual harm/risk to residents related to residents who were incontinent. The scope of the issue was determined to be a level 3, as this issue was found in all of the residents with incontinence issues who were inspected upon. The home had a level 3 compliance history, as a WN was issued under the LTCHA, 2007, r.51(2) - Resident Quality Inspection (#2016_168202_0013), on May 18, 2016. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019(A1)

Order # / Ordre no : 004

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 must be compliant with r. 50 (2) of the LTCHA.

Specifically, the licensee shall ensure the following:

1) Prepare, submit and implement a plan to ensure that residents #014, #030, and #031, and every other resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, 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.

2) The plan must also include that each resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff.

3) The plan must include time lines of tasks to be completed and person(s) responsible for completing the tasks.

4) Educate all RPNs, RNs, RDs, and members of the management team on the plan(s) developed and implemented.

5) Keep a documented record of all plans developed and implemented, and education provided to the staff.

The plan is to be submitted to the CESAO within 10 business days, to the email address of CentralEastSAO.MOH@ontario.ca, attention Inspector #672, Jennifer Batten.

Grounds / Motifs :

1. The licensee has failed to ensure that residents #014, #030, and #031 were assessed by the Registered Dietitian, who was a member of the staff of the home; and any changes made to the resident's plan of care related to nutrition and hydration specific to skin integrity concerns, were implemented.

During transition from Stage I to Stage II of the RQI, Skin and Wound care issues triggered through to Stage II for resident #014, related to staff reporting that resident #014 had alterations in skin integrity.

Inspector #672 observed during Stage II of the RQI, that resident #014 had alterations in skin integrity.

During an interview, RPN #104 indicated that resident #014 did have alterations in skin integrity. RPN #104 further indicated that the expectation in the home was that referrals to the Registered Dietitian (RD) were to be completed for all residents exhibiting altered skin integrity, such as skin tears, bruising, or pressure ulcers of Stage II or greater. RPN #104 indicated that all RD referrals should be documented under the 'Assessments' section in PCC, but could not recall submitting an RD referral for resident #014, related to any of the alterations in skin integrity.

During an interview, Wound Care Champion (WCC) #131 indicated the expectation in the home was that a referral was sent to the RD for any new, worsening, or change in skin integrity concerns. WCC #131 further indicated that it was the responsibility of the Registered Staff on the resident home area to send a referral to the RD, if a resident had skin integrity concerns.

Inspector #672 reviewed the progress notes in PCC for resident #014 during a specified time period. The progress notes indicated that on a specified date, there were no observed skin integrity concerns for resident #014. On a later specified date, there was documentation which stated that resident #014 had an alteration in skin integrity. The progress notes further indicated that on a specified date, there was another alteration in skin integrity; on a specified date, there was a different alteration in skin integrity; and on a specified date, there was an alteration in skin integrity to another identified area.

Inspector #672 reviewed the 'Assessments' section in PCC for resident #014 for a specified time period, and did not observe any referrals sent to the RD, related to skin and wound concerns, specific to resident #014's alterations in skin integrity.

During an interview, the RD indicated not being aware that resident #014 had specific alterations in skin integrity. The RD further indicated that the knowledge they did posses of the resident's alterations in skin integrity was gained through the RD's completion of the quarterly resident review, not through any referrals sent. The RD indicated that the expectation in the home was that referrals should be sent to the RD with any change in skin integrity, which included all bruises, abrasions, skin tears,

or pressure ulcers; and all new, worsening, or any other change in condition to a current wound status. The RD indicated that if a referral had been sent related to the alterations in skin integrity for resident #014, an specified order would have been given.

Inspector #672 expanded the scope of residents inspected to three, due to the non-compliance noted related to resident #014, and inspected resident #030, who had alterations in skin integrity; and to resident #031, who also had alterations in skin integrity.

During an interview, RPN #109 indicated that resident #030 had an identified alteration in skin integrity, which required routine identified treatment. RPN #109 further indicated that the expectation in the home was that a referral should be sent to the RD for all resident wounds, or altered skin integrity.

Inspector #672 reviewed the 'Assessments' section for resident #030 in PCC for a specified time period, which revealed that on a specified date, an assessment of skin impairment was completed, which noted there was a skin integrity issue related to resident #030. On another specified date, there was a referral completed to the WCC, related to the resident's alteration in skin integrity.

Inspector #672 reviewed all progress notes for resident #030 completed in PCC for a specified time period, which revealed the resident had multiple instances and areas of alterations in skin integrity.

During an interview, the RD indicated not being aware that resident #030 had current alterations in skin integrity, and was not aware of any of the resident's alterations in skin integrity between a specified time frame.

Resident #031 was admitted to the home on a specified date, with multiple medical diagnoses.

During an interview, RPN #103 indicated that resident #031 had alterations in skin integrity, which required routine identified treatment. RPN #103 further indicated that the expectation in the home was that upon original discovery of an area of altered skin impairment, a referral should be sent to the RD for assessment and follow up.

Inspector #672 reviewed the 'Assessments' section in PCC for resident #031 for a specified time period, which revealed that resident #031 had alterations in skin integrity. The assessments further indicated that the alterations in skin integrity worsened over time, which led to a medical condition; along with sustaining other alterations in skin integrity.

Inspector #672 reviewed the progress notes in PCC for resident #031 for a specified time period, which revealed the resident had multiple instances and areas of alterations in skin integrity.

During an interview, the RD indicated not being aware that resident #031's alterations in skin integrity had worsened, or that the alterations in skin integrity led to a medical condition, until a specified date, when completing the dietary quarterly review, and reviewed resident #031's progress notes as part of the dietary quarterly summary. The RD indicated not receiving referrals related to the progression of the alterations in skin integrity or medical condition, except for one concern on a specified date. The RD further indicated that referrals should be sent to the RD by the Registered Staff related to skin tears, bruising, ulcers, and abrasions; along with any new skin integrity concerns.

During an interview, the DOC indicated that the expectation in the home was that referrals were sent to the RD by the Registered Staff for any new or worsening skin integrity concern, so that the RD could assess the nutrition and hydration aspects of each resident, related to skin integrity issues.

The licensee failed to ensure that resident #014, #030, and #031 were assessed by the Registered Dietitian for all new, and/or worsening skin integrity concerns. [s. 50. (2) (b) (iii)] (672)

2. The licensee has failed to ensure that residents #014, #030, and #031 were reassessed by an RN at least weekly, when clinically indicated, due to exhibited altered skin integrity.

During transition from Stage I to Stage II of the RQI, Skin and Wound care issues triggered through to Stage II for resident #014, related to staff reporting that resident #014 had alterations in skin integrity present.

Inspector #672 observed during Stage II of the RQI, that resident #014 had

alterations in skin integrity.

During an interview, RPN #104 indicated the expectation in the home was that every identified area of altered skin integrity should be assessed and documented on, on a weekly basis.

Inspector #672 reviewed the internal policy related to identified areas of altered skin integrity, Policy Number: 03-07, Date of Origin: June 2010, which stated the following:

"The Skin Care Coordinator or delegate will assess and document the assessment of all identified areas of altered skin integrity that are assessed at an identified stage weekly."

The policy went on to state under the 'Documentation' heading:

• "Altered Skin Care Record – used to document the status of the identified area of altered skin integrity

• Progress notes – used to document the progression of altered skin healing, resident response to treatment, assessments completed and any other care related interventions associated with the identified area of altered skin integrity such as referrals to specialists etc."

Inspector #672 reviewed all progress notes for resident #014 for a specified time period, which revealed that on a specified date, resident #014 was observed to have an alteration in skin integrity, and on a future specified date, was noted to have another alteration in skin integrity. On another specified date, the progress notes indicated that resident #014 other alterations in skin integrity.

Inspector #672 reviewed the assessments section and progress notes for resident #014 in Point Click Care (PCC) for a specified time period, which revealed the following:

• A specified alteration in skin integrity was first noted on a specified date. There were assessments completed on two specified dates, but not on two other specified dates.

• During a specified month, there were assessments completed regarding the specified alteration in skin integrity on three specified dates, but not on one other specified date.

• During a specified month, there were assessments completed regarding the specified alteration in skin integrity on two specified dates, but not on two others.

• During a specified month, there were assessments completed regarding the specified alteration in skin integrity on three specified dates, but not on one other.

Related to a second specified alteration in skin integrity, Inspector #672 reviewed the documentation in PCC for a specified time period, which revealed the following:

• The second specified alteration in skin integrity was first noted on a specified date. There were assessments completed regarding the second specified alteration in skin integrity on one date, but not on one other specified date.

• During a specified month, there were assessments completed regarding the second specified alteration in skin integrity on one specified date, but not on three others.

• During a specified month, review of the documentation revealed that the area was not assessed and documented on at all during the month,.

• During a specified month, there were assessments completed regarding the second specified alteration in skin integrity on one specified date, not on three others.

Related to a third specified alteration in skin integrity, the documentation in PCC was reviewed for a specified time period, which revealed the following:

• The third specified alteration in skin integrity was first noted on a specified date. Review of the documentation revealed that after the area was first noted, there was no further assessment of, or documentation on the area during a specified month.

• During a specified month, there were assessments completed on the third specified alteration in skin integrity on one specified date, but not on four others.

Inspector #672 expanded the scope of residents inspected to three, related to the non-compliance noted in resident #014's current plan of care, and inspected resident #030, who had alterations in skin integrity, and resident #031, who also exhibited alterations in skin integrity.

Resident #030 was admitted to the home on a specified date, with specified medical diagnoses. Resident #030 was noted to have an alteration in skin integrity.

During an interview, RPN #109 indicated that resident #030 currently had an alteration in skin integrity, which required a specified treatment.

Inspector #672 reviewed all progress notes and assessments for resident #030 for a specified period of time. Review of the progress notes revealed that on a specified date, an assessment of skin impairment was completed, which noted there was a skin integrity issue present. Inspector #672 reviewed the assessments section and progress notes for resident #030 in Point Click Care (PCC) for a specified period of time, which revealed the following:

• Resident #030's alteration in skin integrity was first noted on a specified date. There were assessments completed on two dates, but not on two others.

• During a specified month, there were no assessments with documentation completed.

During an interview, RPN #109 indicated the expectation in the home was that every specified skin integrity concern should be assessed and documented on, on a weekly basis.

Resident #031 was admitted to the home on a specified date, with identified medical diagnoses. Resident #031 also had specified skin integrity concerns.

During an interview, RPN #103 indicated resident #031 had an alteration in skin integrity, with several interventions in place. Resident #031 also received specific skin integrity treatments, due to a medical condition.

Inspector #672 reviewed the progress notes and assessment section in PCC for

resident #031 for a specified period of time. Review of the progress notes revealed that on a specified date, an identified alteration in skin integrity was present. Inspector #672 reviewed the assessments section and progress notes for resident #031 in PCC for a specified period of time, which revealed the following:

• During a specified month, there were assessments related to the identified alteration in skin integrity completed on two specified dates, but not on three others.

• During a specified month, there were assessments related to the identified alteration in skin integrity completed on two specified dates, but not on three others.

During an interview, the Wound Care Champion (WCC), RN #131 indicated that part of the role of the WCC was to ensure that each identified area of altered skin integrity received a weekly assessment with corresponding documentation, but approximately one year ago, the WCC informed the DOC that not enough time was allocated in the role of the WCC for that task to be completed, therefore the task was transferred to the RPNs on the units to complete. The WCC further indicated that all of the RPNs had received education and training regarding specific areas of altered skin integrity care, the internal Skin and Wound Care policies and procedures, and the expectations in the home regarding weekly assessments and documentation, prior to taking over responsibility of the weekly altered skin assessments.

During an interview, the DOC indicated being aware that the weekly altered skin integrity assessments and documentation were not being completed, after being informed by the WCC approximately one year ago. The DOC further indicated there was not currently a plan in place for ensuring that the weekly areas of altered skin integrity assessments were being completed by the nursing staff.

The licensee failed to ensure that residents #014, #030, and #031 were reassessed by an RN at least weekly, when clinically indicated, due to exhibited altered skin integrity. [s. 50. (2) (b) (iv)]

The severity of this issue was determined to be a level 2, as there was the potential of actual harm/risk of harm to residents, related to resident #014, #030, and #031 not being assessed by the Registered Dietitian for all new, and/or worsening skin

integrity concerns, and were not reassessed by registered staff at least weekly when clinically indicated, due to exhibited altered skin integrity. The scope of the issue was determined to be a level 3, as this issue was found in all three of the residents with skin integrity concerns who were inspected upon. The home had a level 2 compliance history, as the home had previous unrelated non-compliances, within the previous 36 months.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 28, 2019(A1)

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 7 th day of February, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JENNIFER BATTEN (672) - (A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Service Area Office / Bureau régional de services : Central East Service Area Office