Ontario

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

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

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

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


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

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

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## Public Copy/Copie 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 |
|---|---|---|---|
| Sep 18, 2019 | 2019_768693_0021 | 013476-19, 013549-19, 013795-19, 015374-19, 015440-19, 015539-19, 015542-19, 015650-19 | Critical Incident System |

### Licensee/Titulaire de permis

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

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

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

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

MELISSA HAMILTON (693), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621)

### Inspection Summary/Résumé de l'inspection

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

**This inspection was conducted on the following date(s): August 26 to August 30, and September 3 to 6, 2019.**

**Inspector David Schaefer (757) was also in attendance at this inspection.**

**The following intakes were inspected upon during this Critical Incident System (CIS) inspection:**
**- three logs regarding improper care of residents;**
**- one log regarding alleged resident to resident abuse;**
**- three logs regarding resident falls; and**
**- one log regarding alleged staff to resident neglect.**

**Complaint inspection #2019_768693_0020 and Follow Up inspection #2019_768693_0022 were conducted concurrently with this Critical Incident System (CIS) inspection.**

**During the course of the inspection, the inspector(s) spoke with the Extendicare Assist Regional Director, Extendicare Assist LTC Consultant, Vice President (VP) of Seniors Health, Medical Director, Administrator, Directors of Care (DOCs), Clinical Managers (CMs),Supervisor of Building Services, Food Service Manager (FSM), Coordinators of Clinical Learning and Practice, Psychogeriatric Resource Consultant (PRC), Resident Assessment Instrument (RAI) Coordinators, Occupational Therapist (OT), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Worker (PSWs), residents, their family members, and substitute decision makers (SDMs).**

**The following Inspection Protocols were used during this inspection:**
**Falls Prevention**
**Nutrition and Hydration**
**Prevention of Abuse, Neglect and Retaliation**
**Responsive Behaviours**

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

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

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

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

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

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the staff and others involved in the different aspects of care of the resident collaborated with each other.

A Critical Incident System (CIS) report was submitted to the Director on an identified date, related to resident #005 who had fallen and was found to be in a specific position. The report had indicated that the resident was ordered an identified safety intervention, on a specific date.

Inspector #577 reviewed the physician's orders, which identified an order for an identified safety intervention. The physician's progress note identified that that the resident had been removing the intervention and was a fall risk.

A review of a safety intervention consent, identified a specific safety device, and verbal

consent from the SDM.

A review of resident #005's current care plan identified that resident used an identified safety intervention when utilizing their ambulation device.

During observations made during this inspection, the Inspector observed resident #005 utilizing their ambulation device, with a safety device secured, without a specified alteration of the intervention.

During observations made on a specified date, Inspector #577 noted resident #005 utilizing their ambulation device without their safety intervention.

During an interview with PSW #117, they reported to the Inspector, that they had never seen a specification on the safety intervention, on resident #005's ambulation device.

During an interview with RPN #118, together with Inspector #577, they reviewed the order for a specified safety intervention. They reported that they had never seen the specified safety intervention on resident #005's ambulation device.

During an interview with OT #119, they reported that they had not been made aware of, or received a referral for the specified safety intervention on an identified date, or thereafter for resident #005.

During an interview with CM #103, together with the Inspector, they reviewed the physician order for an identified safety intervention. They reported that they were not aware of the order for the safety intervention and that staff should have made a referral to Occupational Therapy (OT). [s. 6. (4) (a)]

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

A CIS report was received by the Director on an identified date, concerning suspicions of staff to resident neglect of resident #001, by PSW #106, on another identified date. The CIS report identified the resident's substitute decision maker (SDM) brought forward concerns to Clinical Manager #107, that personal care for resident #004 had not been provided; the SDM reported that they had found the resident, with specified evidence that care had not been provided when they arrived to the home that morning.

A review of the home's investigation notes contained an interview, from an identified date, by Clinical Manager #107 with PSW #106, which identified that PSW #106 confirmed they had not checked resident #001 on the morning of the incident; and had not reviewed the resident's care plan. Additionally, documentation of video footage from the identified date, identified that resident #001 had been redirected back to their room at a specified time, and did not leave their room until an identified number of hours later. Additionally, video footage documentation found no PSW had entered into the resident's room for a period of approximately seven hours, between a specified time period. The investigation record also identified a letter of counsel addressed from the home to PSW #106, on an identified date, which indicated that the PSW did not review or follow the resident's plan of care, with respect to this incident.

Inspector #621 reviewed resident #001's care plan in effect at the time of the incident, which identified the following:
- Under specified foci, the care plan identified individualized care that staff were to provide to the resident.

During interviews with PSW #115 and RPN #116, they reported to Inspector #621 that resident #001 usually experienced continence concerns at a specific time of day and required an identified level of assistance with personal care. PSW #115 and RPN #116 further identified that identified care for the resident usually consisted of specified personal care, and provision of an identified meal.

During an interview with CM #107, they reported to the Inspector that PSW #106 was found on the specific shift of an identified date, to have not provided any monitoring checks, or personal care to resident #001, as per their plan of care. [s. 6. (7)]

3. A CIS report was submitted to the Director on an identified date, related to resident #005 who had fallen and was found positioned in an identified way, underneath a specified intervention. The CIS report had indicated that an intervention had not been in place at the time of the fall, as per the care plan.

A review of resident #005's care plan in place at the time of the fall on an identified date, indicated that resident #005 was to utilize a specified intervention for safety.

During a review of the investigation notes, an interview with Management and PSW #117 had indicated that resident #005, had not had a specified intervention in place for months.

A review of the home's policy, "Care Planning - LTC 2-21" revised March 21, 2018, indicated that a care plan was a guide that consisted of a series of documents that provided information and instructions to the care team regarding the assessed needs, delivered care and outcomes of care.

During an interview with RPN #118, they reported to Inspector #577 that on an identified date, resident #005 did not have a specified intervention in place, and was not sure how long the intervention had not been in place, or if it had ever been used properly.

During an interview with PSW #117, they reported to the Inspector that on an identified date, resident #005 did not have a specific intervention in place.

During an interview with CM #103, they reported to Inspector #577, that during the investigation, it had been determined that a specific intervention was not in use during the time of the fall, and they were not aware of whether the specific intervention had ever been put in place or whether someone had removed the specific intervention. [s. 6. (7)]

4. The licensee has failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months, and at any other time when the resident's care needs changed, or care set out in the plan was no longer necessary.

A CIS report was received by the Director on an identified date, concerning a resident to resident altercation, between resident #003 and #004 on an identified date, with resident #003 sustaining a fall with injury.

During interviews with PSW #112, and RPNs #110 and #111, they reported that both resident #003 and #004 had responsive behaviours. When Inspector #621 inquired as to the specific responsive behaviours for resident #003, they identified the resident expressed over most weeks, identified responsive behaviours, on a daily basis. Further, PSW #112 ad RPNs #110 and #111, stated that resident #003's identified behaviours, not only preceded the incident on an identified date, but continued as active issues during the time of inspection. Additionally, they reported that while resident #003 had identified behaviours prior to the date of the incident, after the fall with a subsequent injury, the resident no longer exhibited the identified behaviour, as they now required a specific level of assistance with ambulation, utilizing a specified ambulation device, both on and off the unit.

During a review of resident #003's care plan that was effective at the time of the identified altercation with resident #004, the Inspector found no responsive behaviour care planning for identified behaviours. Similarly, on review of resident #003's care plan at the time of inspection, the Inspector continued to find no responsive behaviour care planning for identified behaviours. However, the Inspector did find that the care plan for an identified behaviour that was no longer present, continued to be documented as an active care issue in the most current care plan.

Further, on review of resident #003's last full RAI-MDS 2.0, from an identified date, (which was completed prior to the identified altercation with resident #004), section E4 for Behavioural Symptoms, Inspector #621 identified specific sections that reported identified responsive behaviours.

During reviews of resident #003's most current Kardex at the time of inspection, PSW #112, and RPNs #110 and #111 reported to the Inspector, that there was no documented care plan to provide strategies to help address the resident's identified responsive behaviours; and that a care plan for an identified responsive behaviour was still present on the Kardex, but no longer an active issue, due to the resident's change in mobility status after the identified incident.

During a follow up interview with the Regional Director of Extendicare Assist #109 on August 29, 2019, they reported to Inspector #621, that in further consultation with home's staff that day, they could confirm that, at the time of inspection, resident #003 no longer exhibited an identified behaviour, and the plan of care for this identified behaviour should have been removed from the resident's care plan, and was not. Additionally, they reported that the resident continued to have responsive behaviours, as identified in the last full RAI-MDS 2.0 assessment, completed on an identified date, and confirmed that the care plan had not been revised to reflect the resident's current care needs, with respect to responsive behavior management of identified behaviours. [s. 6. (10) (b)]

***Additional Required Actions:***

***CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other, (a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the following was complied with in respect to each of the organized programs required under section 8 to 16 of the Act, and each of the interdisciplinary programs required under section 48 of Ontario Regulation 79/10.

Specifically, the licensee has failed to ensure that the Continence Care and Bowel Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A CIS report was received by the Director on an identified date, concerning suspicions of staff to resident neglect of resident #001 on an identified date, with respect to identified areas of care.

A review of the home's policy titled "Continence Care and Bowel Management Program,

LTC 3-70", as provided to Inspector #621 by Clinical Manager #107 on September 3, 2019, it was noted that the program policy was dated from March 2016.

During an interview with CM #107, they informed the Inspector that the home had not yet implemented Extendicare's continence care program policies and procedures, and that the home's policy equivalent, which was still being utilized, was more than a year old.

During an interview with the Administrator on Sept 3, 2019, they confirmed that the home was still rolling out education and implementation of the Extendicare continence care program, and that at the time of inspection, this still had not been completed. Additionally, they stated that it was their expectation that home's continence care program policies and procedures had been reviewed and updated at least annually. [s. 30. (1) 3.]

2. Specifically, the licensee has failed to ensure that the Falls Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A CIS report was submitted to the Director, on an identified date, for an incident that caused injury to resident #009, for which the resident was taken to the hospital and resulted in a significant change in the resident's health status. The report further identified that the incident was an unwitnessed fall, and the resident had sustained an injury.

Inspector #693 reviewed the home's policy, titled, "Falls Management, LTC 3-60" as provided to Inspector #577, by The Extendicare Assist Regional Director #109. It was noted that the program policy indicated that the home adopted the Extendicare Policy on December 18, 2017. Inspector #693 reviewed the policy and noted that the attached Extendicare program policy, titled, "Falls Prevention and Management Program, RC-15-01-01", was last updated in February 2017.

During an interview with the Administrator, they stated they assumed that Extendicare had an updated Falls Prevention policy, but that the home may not have implemented the most recent policy yet, and that they would confirm this and get back to the Inspector. The Administrator, later confirmed to Inspector #577, that the home's Falls Prevention and Management Program and policy that was in use was implemented in the home on December 18, 2017, and approved by the St Joseph's Care Group, Seniors Health Quality Safety and Risk Committee on March 21, 2018. The Administrator stated that the

home was using a policy that was not updated within the last year, for the Falls Prevention and Management Program.

During and interview with the Extendicare Assist LTC Consultant, they indicated that they knew that the home had not fully implemented Extendicare policies, and that Extendicare's the Falls Prevention and Management Program was last updated in June, 2019. They stated that they would confirm with DOC #105, when the Falls Prevention and Management Program would be implemented in the home.

During an interview with DOC #105, they stated that they, together with the VP of Seniors Health, created a schedule with prioritization for implementing all Extendicare policies. The DOC stated that the Falls Prevention and Management program was out of date as it had not been reviewed in the last year, and that the home planed to update and review the policy to match Extendicare's Falls Prevention Program, last updated in June, 2019 in the near future. [s. 30. (1) 3.]

***Additional Required Actions:***

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

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.**

**Findings/Faits saillants :**

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

A CIS report was submitted to the Director on an identified date, concerning resident #008 who had fallen and sustained an injury. The report indicated that the resident had received morning care from PSW #120, and when they had turned away from the bedside, the resident fell and sustained an injury.

A review of resident #008's care plan in place at the time of the fall, identified that resident #008 required assistance from a specified number of staff members.

A review of the home's incident report identified that resident #008 had received morning care from PSW #120, where they had the bed at waist level and had positioned an intervention; PSW #120 reported that they had turned around to place an item into the garbage and the resident fell. The resident was transferred to acute care for further assessment and had been diagnosed with an identified injury.

A review of the investigation notes identified a letter from an identified date, from CM #107 to PSW #120. The letter indicated that PSW #120 had not followed the care plan in regards to bed mobility, continence, bathing and transferring. Further, it was expected that they would have the appropriate number of staff members present to apply an identified intervention and perform care as per the care plan. Interview notes indicated that after the fall, PSW #120 and another staff member transferred the resident into a chair, after they fell, with an identified transfer method.

During an interview with PSW #120, they reported to Inspector #577 that they had not read resident #008's care plan that day and had performed all of their care without assistance. The PSW reported they were not aware that they were not to position an identified intervention under a resident without assistance.

A review of the home's, "Safe Lifting With Care Program- LTC-5-110", revised March 21, 2018, indicated that two trained staff were required at all times when they performed a mechanical lift., two staff were required to position the sling underneath the resident and centering the resident within the sling.

During an interview with CM #107, they reported that PSW #120 had not followed the mechanical lift policy and had not followed resident #008's plan of care. [s. 36.]

***Additional Required Actions:***

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

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs**

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

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that an interdisciplinary falls prevention and management program to reduce the incidence of falls and the risk of injury was developed and implemented in the home.

A CIS report was submitted to the Director, on an identified date, for an incident that caused injury to resident #009, for which the resident was taken to the hospital and resulted in a significant change in the resident's health status. The report further identified that the incident was an unwitnessed fall, and the resident had sustained an injury.

Inspector #693 reviewed resident #009's medical record and identified a form titled, "Clinical Monitoring Record." The record indicated that resident #009 fell on an identified date, at a specified time and that the monitoring on this record was to finish on an identified date; as well, the following were to be monitored every hour for, four hours and then every eight hours for 72 hours: neurological vital signs for an unwitnessed fall, vital

signs, pain and changes in behaviour.

A review of the Clinical Monitoring Record initiated for resident #009's fall on a specified date identified:
- one out of 13, or eight per cent, of the pain assessment monitoring entries were not recorded;
- seven out of 13, or 54 per cent, of the vital sign monitoring entries were not documented; and;
- seven out of 13, or 54 per cent, of the neurological vital sign monitoring entries were not documented.

In addition, the Inspector noted that, the first set of vital signs and neurological vital signs were recorded at an identified time, and the second set was not completed until a later identified time. The Inspector also noted that between the second and third entries there was a 16 hour time gap, between the third and fourth entries there was a 14 hour time gap, between the fourth and fifth entries there was an 11 hour time gap, and between the sixth and seventh entries there was a 13 hour time gap. As well, the Inspector noted that the second and third entries for vital signs, did not include an oxygen saturation, and the second entry did not include a blood pressure, as the record indicated was to be completed.

During an interview with RPN #102, they stated that when a resident had a fall the nursing staff had a set of instructions to follow, that indicated what they were to do. They stated that the instructions were part of a package used for every fall and stapled together with a "Post Fall Clinical Pathway" form, a "Clinical Monitoring Record", and a "Post-Fall Team Huddle Process" sheet. RPN #102 provided Inspector #693 a copy of these instructions. The instructions indicted that the process they outlined was to be followed for every fall. The instructions identified that the Clinical Monitoring Record was to be initiated, and used to assess neurological vital signs, vital signs, pain, bruising, changes in functional and cognitive status and changes in range of motion, as well that staff were to document the results of all assessments and actions taken during the 72 hours post-fall follow-up in MED e-care as a follow up note to the original incident. RPN #102 indicated that if a resident fell and hit their head or had an unwitnessed fall, nursing staff were to start the Clinical Monitoring Record, and follow the instructions on the form, regarding pain assessments, vital signs and neurological vital signs. RPN #102 reviewed the Clinical Monitoring Record, in resident #009's medical record for the resident's fall on an identified date. The RPN indicated that this form was not filled out properly, as some of the documented vital signs were missing information such as blood pressure and

oxygen saturation; as well, that there were many entries missing from the record, as the record was not completed as it should have been; every one hour for four hours, and then every eight hours for 72 hours post-fall.

Inspector #693 reviewed the home's policy, from Extendicare, titled, "Fall Prevention and Management Program, RC-15-0101", last updated February 2017. The policy indicated that that if a resident experienced an unwitnessed fall, staff were to have completed a "Clinical Monitoring Record." The policy also directed staff to assess the following; for 72 hours post fall, at each shift: pain, bruising, change in functional status, change in cognitive status; and changes in range of motion.

Inspector #693 reviewed the e-notes for resident #009, electronically on MED e-care, for the 72 hours post fall. The e-notes indicate that during the 72 hours post fall, bruising was documented as assessed on three out of eight; or 38 per cent of shifts, pain was documented as assessed on one out of eight; or 13 per cent of shifts, and changes in functional or cognitive status were documented as assessed on three out of eight; or 38 per cent of shifts.

During an interview with CM #103, they stated that when a resident had an unwitnessed fall, staff were to initiate and complete the Clinical Monitoring Record, and assess and document results for pain, vital signs, neurological vital signs, changes in functional or cognitive status, and changes in range of motion. The CM reviewed the documentation for resident #009's unwitnessed fall on an identified date, and confirmed that the Clinical Monitoring Record was not fully completed, and the resident was not monitored, as required by the Falls Prevention Program. [s. 48. (1) 1.]

2. a) A CIS report was submitted to the Director on an identified date, concerning resident #008 who had fallen and sustained an injury.

A review of a document titled, "Post Fall Procedure Checklist", directed staff to implement the post-fall clinical pathway; initiate clinical monitoring record; transfer to acute care for serious injury; post fall assessment tool; post fall team huddle; notification of SDM/POA and physician; fall incident note; client safety report if fall with injury; For 72 hours post fall, staff were to document on the clinical monitoring record the following every hour for the first four hours, then every eight hours for 72 hours: neurological vital signs (if head injury or unwitnessed fall), vital signs, pain (using numerical rating scale, wong-baker faces or PAIN-AD scale), bruising; document results of all assessments (including which pain rating scale was used) and actions taken during the 72 hour post-fall follow-up as a

follow up note; Manager to initiate post fall investigation if clinically indicated (serious injury, multiple falls); fall factors checklist.

During a record review, Inspector #577 found that the Clinical Monitoring Record had not been implemented at all, to monitor vital signs, pain and bruising. A review of the progress notes indicated that vital signs were completed at the time of the fall incident and upon return from the hospital nine hours later. There were no vital signs recorded every eight hours for 72 hours. Pain assessments were not being completed every eight hours for 72 hours; a review of the progress notes indicated one pain assessment on an identified date, two pain assessments on another identified date, two pain assessments on another identified date, and one pain assessment on another identified date.

During an interview with RPN #121, they reported to Inspector #577 that staff were required to follow the "Post Fall Procedure Checklist" which guided staff on assessment documentation immediately after a fall and 72 hrs post fall; and they were required to utilize the Clinical Monitoring Record.

During an interview with CM #107, they confirmed that staff were not following and implementing the home's Falls Program, as staff had not completed vital signs every eight hours for 72 hours, and staff had not implemented the Clinical Monitoring Record to record vital signs and pain assessments. They further confirmed that the "Post fall Investigation Process" and "Fall Factors Checklist" documents were not completed by the Manager or RN.

b) A CIS report was submitted to the Director on an identified date, related to resident #005 who had fallen, been found in an identified position, and sustained injuries.

During a record review, Inspector #577 found that the Clinical Monitoring Record had been implemented to monitor vital signs, but the vital signs were not completed every eight hours for 72 hours. Vital signs were completed at the time of the fall, upon return from the hospital nine hours later, and then on two occasions two days later. There were no pain assessments completed and neurological vital signs were completed three times.

During an interview with CM #103, they confirmed with Inspector #577 that vital signs and neurological vital signs were not consistently completed during the 72 hours post fall and a safety report had not been completed.

During an interview with The Extendicare Regional Director #109, they confirmed with Inspector #577 that the staff had not implemented the falls program; the neurological vital signs and vital signs were not completed every eight hours for 72 hours; pain assessments were not completed as required and a safety report had not been implemented. [s. 48. (1) 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 the following interdisciplinary programs are developed and implemented in the home: 1. A falls prevention and management program to reduce the incidence of falls and the risk of injury., to be implemented voluntarily.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records**
**Every licensee of a long-term care home shall ensure that,**
**(a) a written record is created and maintained for each resident of the home; and**
**(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

A CIS report was received by the Director on an identified date, concerning suspicions of staff to resident neglect of resident #001, by PSW #106, on an identified date. The CIS report identified the resident's SDM brought forward concerns to CM #107, identifying that they felt personal care for resident #004 had not been provided, including provision of an identified meal, prior to their arrival to the unit.

A review of the home's investigation notes contained an interview from an identified date,

by Clinical Manager #107 with PSW #106, which identified that PSW #106 confirmed they had not checked resident #001 on the morning of the incident. Additionally, documentation of video footage from a specified date, identified that resident #001 had been redirected back to their room at an identified time, and did not leave their room until a later identified time. Additionally, video footage documentation found no PSW had entered the resident's room for a period of approximately seven hours.

In a review of dietary intake records from an identified date, Inspector #621 found documentation from PSW #106 at a specified time, which coded "S=Sleeping", as the reason for why resident #001 had not consumed an identified meal or a beverage at the identified nourishment service that day.

During an interview with CM #107, they confirmed with the Inspector that PSW #106 was assigned to provide care to resident #001 during the identified shift on a specified date; that neither PSW #106, nor any other PSW completed care or comfort checks for the resident during a specified time period; and that documentation of the video footage, showed that the resident did not leave their room during an identified time period. In a review of resident #001's dietary report for an identified date, with CM#107, they identified that documentation in the dietary report had not been changed since PSW #106 coded information into the written record that the resident was sleeping during a specified meal time and nourishment service on an identified date. [s. 231. (b)]

2. A CIS report was received by the Director on an identified date, concerning suspicions of staff to resident neglect of resident #001, by PSW #106, on an identified date.

A review of the employment records of PSW #106, identified a letter from the home related to the identified incident; as well as a subsequent letter from a specified date, which identified that on a specific date, it was discovered that PSW #106 had documented that they had provided care to a resident, when they later admitted that they had not been able to provide the documented care.

During an interview with the Regional Director of Extendicare Assist #109 and DOC #100, they reported to Inspector #621 that the letter for the identified incident, was related to PSW #106 documenting that they provided identified personal care to resident #011, when it was determined through investigation by Clinical Manager #107, that they had not.

Inspector #621 reviewed resident #011's care plan, in effect at the time of the identified

incident. The resident's specified care plan identified the resident required an identified level of assistance from a specified number of staff with specified continence care.

In a review of the home's internal investigation notes, a meeting with PSW #106 on an identified date, identified that the PSW had documented that they had provided specific care to resident #011, and that during the meeting with the home, they reported that they thought someone else had provided specific care to the resident, and that they had forgotten to update the documentation. Further the interview notes identified that this had been the second time that PSW #106 had falsified documentation.

During review of the home's Flow Sheet records for resident #011 for an identified date, with Regional Director of Extendicare Assist #109 and DOC #100, it was confirmed with the Inspector that PSW #106 documented that on the day shift of an identified date, the resident was experiencing continence issues at an identified time and was provided with specific care, by the PSW, and subsequently at a later identified time, they had provided other specific care to the resident. The Regional Director of Extendicare Assist #109 confirmed to Inspector #621 that resident #011's written record for identified cared in the PSW's Flow Sheet record for this resident, was not accurate and up to date at the time of inspection. [s. 231. (b)]

3. A CIS report was received by the Director, on an identified date, for the improper or incompetent treatment of resident #010 on an identified date. The report further indicated that on another identified date, the home received a verbal complaint from resident #010's a family member. The family member stated that on an identified date, they were visiting resident #010 at a specific time, and found resident #010 with continence concerns.

Inspector #693 reviewed resident #010's care plan that was current on the date of the incident. The care plan, last updated on an identified date, indicated that resident #010 required a specified level of assistance of staff with specified care, staff were to encourage the resident to use a continence product; as well, the resident refused aspects of identified care, and experienced identified continence issues.

Inspector #693 reviewed the Point of Care (POC) flowsheet charting, on MED e-care, for resident #010, for an identified shift. The interventions, titled, "Care Plan: Care has been provided as outlined in the careplan" was documented as provided, A specific care area was documented as "I" for independent, and a specific care provision was documented as one time by PSW #104 at an identified time.

The home's investigation file contained notes from an interview with DOC #100, CM #103, and PSW #104, in which PSW #104 stated that they did not provide any specified personal care to resident #010 on an identified date; as well, the PSW indicated that they had falsely documented the care as being provided, on POC. Further, the investigation file contained a copy of a letter from an identified date, addressed to PSW #104. The letter indicated that the PSW had documented on the POC documentation that they had provided resident care although they had not done so.

During an interview with CM #103 they confirmed that the POC charting for resident #010, for an identified date, on a specified shift was inaccurate. They stated that the POC flowsheet indicated that the care was provided as per the care plan, that specified personal care was provided, and that this was false documentation as the POC flowsheet should have been kept up to date to state that the resident did not receive this care. [s. 231. (b)]

4. A CIS report was submitted to the Director on an identified date, related to resident #005 who had fallen out of their bed and was found in a specified position, underneath an identified device.

Inspector #577 reviewed the physician's orders from an identified date, which identified an order for a specified intervention. The physician's progress note identified that that the resident had been removing their identified intervention and was a certain level of risk for falls.

A review of a restraint consent from an identified date, identified a specific intervention with an identified modification, and verbal consent from the SDM.

During observations on August 26, 28 and 29, 2019, Inspector observed resident #005 utilizing their ambulation device, with a specific intervention in place.

Inspector #577 reviewed the current Electronic Medication Administration Records (eMAR's) for resident #005 which identified two separate orders: a specific intervention and a specific intervention with an identified modification. During a review of the eMAR documentation from a specified period of time, the Inspector identified a number of dates, where the specific intervention with an identified modification had been documented as applied.

During an interview with PSW #117, they reported to the Inspector that they had never seen the specific intervention with an identified modification in use for resident #005's ambulation device.

During an interview with RPN #118, together with Inspector #577, they reviewed the order for the specific intervention with an identified modification. They reported that they had never seen the specific intervention with an identified modification in use on resident #005's ambulation device.

During an interview with CM #103, together with the Inspector, they reviewed the physician order for the specific intervention with an identified modification and the eMAR documentation. They confirmed that staff had been documenting the specific intervention with an identified modification on the eMAR when it had not been applied. [s. 231. (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 a written record is created and maintained for each resident of the home; and the resident's written record is kept up to date at all times., to be implemented voluntarily.***

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**WN #6: 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 failed to ensure that residents were not neglected by the licensee or staff.

A CIS report was received by the Director, on an identified date, for the improper or incompetent treatment of resident #010 on a previous date. The report further indicated

that on this date, the home received a verbal complaint from resident #010's a family member. The family member stated that on an identified date, they were visiting resident #010 at 1630 hrs, and found resident #010 in a saturated continence product, with sheets that were soiled.

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

Inspector #693 reviewed the home's policy, from Extendicare, titled " Zero Tolerance of Resident Abuse and Neglect Program, RC-02-01-01", last updated June 2019. The policy identified that the home was committed to providing a safe and secure environment, in which all residents were treated with dignity and respect and were protected from all forms of abuse or neglect at all times. Additionally, the policy stated that neglect was the failure to provide a resident with treatment, care, services or assistance required for health, safety or well-being- includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. The policy listed clothing soiled as an example of neglect, as well as bed and linens visibly soiled with stool or urine.

Inspector #693 reviewed the home's policy, "Continence Care and Bowel Management Program, LTC 3-70", approved in March 2016. The program included the "Continence Care and Bowel Management Toolkit", revised in May 2016. The toolkit identified that PSWs were to follow the plan of care for continence care interventions, check and change residents who used continence care products as per the plan of care, document bladder and bowel functioning, and report to the registered staff.

Inspector #693 obtained a copy of the home's policy, titled "Activities of Daily Living, LTC 8-10", approved in June 2018, specifically "Care and Comfort Rounds, RC-12-01-06", last updated in February 2017, from The Administrator. The policy indicated that hourly rounding was to be completed.

Additional non-compliance related to this incident was issued under O. Reg 79/10, s. 231, please refer to WN #5, finding #3 for further details.

A review of the home's investigation file indicated that PSW #104 was caring for resident #010, on a specific shift on an identified date. The notes indicated that the PSW was

interviewed by DOC #100 and CM #103, and had stated to them that they had provided continence care to resident #010 at a specific time of day, on an identified date, and after that the resident had refused care on a specific number of occasions. They stated that when they checked on resident #010 at an identified time, they did not notice that the bed was soiled.

The home's investigation file indicated that on an identified date, CM #103 reviewed the home's video footage and confirmed that on the specified date, PSW #104 delivered meal trays to the resident and did not provide any other care to the resident, as well that the resident was not provided with continence care at anytime during the specified shift, on the identified date. The file included, handwritten notes from an additional meeting with DOC #100, CM #103, and PSW #104, where the PSW indicated that they did not change or attempt to change resident #010 throughout the shift, on an identified date. Further, the investigation file Included a copy of written letter, from an identified date, addressed to PSW #104. The letter indicated that the employee failed to provide any care to a resident that they were responsible to care for; as well, they acknowledged that they did not attempt to provide care. The letter also indicated that the PSW had documented on the Point of Care (POC) documentation that they had provided resident care although they had not done so. The letter indicated that the PSW's actions constituted neglect.

During an interview with CM #103, they showed Inspector #693 photographs that resident #010's family member had taken on an identified date, of the resident's bed. The photographs showed that the bed was visibly stained and saturated with an identified bodily substance beside the resident's specified areas of the body. CM #103 stated that the home's investigation showed that the allegations of improper care by the resident's family member were founded for neglect of resident #010. CM #103 reported that PSW #104 did not provide any care, except delivery of meal trays, for resident #010 on an identified date, between a specific time range, and had neglected resident #010. [s. 19. (1)]

2. A CIS report was submitted to the Director on an identified date, related to resident #005 who had fallen, been found in an identified position, and sustained injuries.

Additional non-compliance related to this incident was issued under O.Reg 79/10, s. 48. (1)., please refer to WN #4, finding #2 for further details.

Additional non-compliance related to this incident was issued under LTCHA, 2007 S.O.

2007, c.8, s. 6. (4)., please refer to WN #1, finding #1 for further details.

Additional non-compliance related to this incident was issued under LTCHA, 2007 S.O. 2007, c.8, s. 6. (7)., please refer to WN #1, finding #3 for further details.

A review of resident #005's progress notes from a specified date, identified that at an identified time, RPN #118 responded to a call bell that had been pulled from the wall. Resident #005 had been found in an identified position, in their room. The resident was found to have fallen.

A review of the investigation notes, identified a description of the video footage from an identified date, which revealed that staff had last checked on resident #005 at an identified time; staff interviews from staff who had worked a specific shift, had confirmed that resident #005's door was closed, and then at an identified time, staff had responded to resident #005's call bell, where they were found to have sustained a fall and been stuck under a specified device in an identified position. A letter addressed to PSW #122, indicated that resident #005 required a specific intervention and at the time of the fall, the intervention was not in place. Care and comfort rounds were reviewed and they were reminded to have ensured that they were completing hourly checks on all residents during their shift. A letter addressed to PSW #117 indicated that the investigation determined that they had not completed a care and comfort check of their residents at the beginning of their shift; resident #005 had fallen, and was found on the floor in distress; and that their actions constituted neglect.

During an interview with RPN #118, they reported to Inspector #577, that on an identified date, they had responded to a call bell that had been pulled out of the wall by resident #005 and found the resident trapped underneath a specific device, where the device had been on top of their body in identified areas; reported they lifted the device off resident #005, they had injuries and had been sent to an acute care hospital for assessment. They further reported that resident #005 did not have a specific intervention on their bed and weren't sure how long the intervention had been off the bed or if it had ever been put on their bed.

During an interview with PSW #117, they reported that they were assigned care of resident #005 on an identified date; reported that the resident did not have a specific intervention on their bed, they had fallen and an identified device was on top of them; the resident had several apparent identified injuries.

During an interview with CM #103, they reported to Inspector #577 that resident #005 had fallen and was found trapped underneath an identified device. The staff who worked an identified shift had not checked resident #005 at an identified time and the video footage had confirmed that the resident was last checked at an identified time, and staff who worked another identified shift had not checked the resident at the beginning of their shift; staff were required to do hourly comfort rounds; PSW #122 had confirmed that there wasn't a specific intervention on resident #005's bed and was not sure whether the intervention had ever put on the bed or if/when someone had removed the intervention.

During an interview with The Extendicare Regional Director #109, they reported to Inspector #577 that that a review of video footage from an identified date, revealed that PSW #117 had not completed a comfort round for resident #005 when they arrived on shift; resident #005 was found trapped underneath an identified device, had been lying on the device controls and RPN #118 had pushed the device off the resident. They further reported that PSW #117's actions constituted neglect of resident #005. [s. 19. (1)]

3. A CIS report was submitted to the Director on an identified date, concerning resident #008 who had fallen and sustained an injury. The report indicated that the resident had received personal care from PSW #120, and when they had turned away from the bedside, the resident fell, and sustained an injury.

Additional non-compliance related to this incident was issued under O. Reg 79/10, s. 36, please refer to WN #3, finding #1, for further details.

During an interview with PSW #120, they reported to Inspector #577 that they had not read resident #008's care plan that day and had performed all personal care and had positioned an intervention underneath resident #008 without assistance. They further reported that they had turned away from the resident, disposed of a continence product into the garbage and the resident had fallen and sustained an injury.

During an interview with CM #107, they reported that PSW #120 had not followed the mechanical lift policy and had not followed resident #008's plan of care, as the care plan had indicated that a specified number of staff were required for transfers, and specific continence care. The home determined that PSW #120 had provided incompetent care to resident #008, as they had sustained an injury. [s. 19. (1)]

4. A Critical Incident System (CIS) report was received by the Director on an identified date, concerning suspicions of staff to resident neglect of resident #001, by PSW #106,

on an identified date. The CIS report identified the resident's substitute decision maker (SDM) brought forward concerns to Clinical Manager #107, that personal care for resident #004 had not been provided, and they had found the resident with continence and other personal care concerns, when they arrived to the home that morning.

Additional non-compliance related to this incident was issued under the Long-Term Care Homes Act (LTCHA), 2007, s, 6. (7), please refer to WN #1, finding #2 for further details.

During interviews with PSW #115 and RPN #116, they reported to Inspector #621 that resident #001 usually experienced continence concerns at a specified time of day and required an identified level of assistance with personal care. PSW #115 and RPN #116 further identified that specific care for the resident usually consisted of a check and/or change of the resident's continence product, specific personal care, monitoring, and to ensure that the resident received a specified meal, if they wanted. PSW #115 also stated that PSWs were to complete a visual check, at least once hourly, on residents in their assignment during the shift.

During an interview with Clinical Manager #107, they reported to the Inspector that PSW #106 was found to have neglected resident #001 on the day shift of an identified date, with respect to their failure to complete hourly monitoring checks of the resident during their shift, and failure to provide personal care to resident #001.

CO #001 was issued during inspection # 2019_746692_0019 pursuant to the Long- Term Care Homes Act (LTCHA), 2007, c.8, s. 19. (1) with a compliance due date of September 30, 2019. As the compliance date was not yet due at the time of this inspection, these findings will be issued as a WN to further support the order. [s. 19. (1)]

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, (a) identifying the behavioural triggers for the resident were identified, where possible; (b) strategies were developed and implemented to respond to these behaviours, where possible; and (c) actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions, and that the resident's responses to interventions were documented.

A CIS report was received by the Director on an identified date, concerning a resident to resident altercation, between resident #003 and #004 on a previous date, with resident #003 sustaining a fall with an injury. Both resident #003 and #004 were identified in the CIS report to have cognitive impairment, with Cognitive Performance Scores (CPS) of an identified vale and another identified value respectively.

During interviews with PSW #112, and RPNs #110 and #111, they reported that both resident #003 and #004 had responsive behaviours. When Inspector #621 inquired as to the specific responsive behaviours for resident #003, they identified the resident expressed identified behaviours. Further, PSW #112 and RPNs #110 and #111 stated that resident #003's identified behaviour, not only preceded the incident on a specified date, but continued as active issues, up to the time of inspection.

a) During a review of resident #003's care plan that was effective at the time of the identified altercation with resident #004, the Inspector found no responsive behaviour care planning for identified behaviours. Similarly, on review of resident #003's care plan

at the time of inspection, the Inspector continued to find no responsive behaviour care planning for identified behaviours.

Further, on review of resident #003's last full RAI-MDS 2.0, from an identified date, (which was completed prior to the identified altercation with resident #004), section E4 for Behavioural Symptoms, Inspector #621 identified specific sections that reported identified responsive behaviours.

During reviews of resident #003's most current Kardex at the time of inspection, PSW #112, and RPNs #110 and #111 reported to the Inspector there was no documented care plan, identifying the resident's behavioural triggers, or strategies to help address the resident's behaviours. Additionally, RPN #110 reviewed the resident's healthcare record, both before and after the identified incident, and identified that there had been no referral made to the PRC for assessment of resident #003's responsive behaviours. Further, RPN #110 indicated that they would have expected there to be a referral to involve PRC, especially since resident #003 had been the instigator of the identified altercation between them and resident #004.

During an interview with the PRC, they confirmed to Inspector #621 that they became involved in assessment of residents with responsive behaviours, and that initiation of an assessment was based on a referral of the resident to their program. The PRC confirmed to the Inspector that resident #003 had never been referred to them by the home for behavioural assessment.

During an interview with the Regional Director of Extendicare Assist #109, they reported to Inspector #621 that it was their expectation that resident #003 was referred to PRC for assessment of their verbal aggression and resistance to care, prior to the identified incident, when the full RAI-MDS assessment, from a previous date, had been completed. They confirmed on review of the most current care plan at the time of inspection, that resident #003 had no responsive behavior care planning for verbal aggression and resistance to care, including identified triggers or strategies implemented for managing those behaviours.

b) A review of resident #004's healthcare record, Inspector #621 identified an incomplete Dementia Observation System (DOS) record in the resident's chart, for an identified date period. The following gaps in documentation were identified:

an identified date – missing documentation from 0730 – 1030 hrs, and 2300 – 0700 hrs;

an identified date – missing documentation from 2300 – 0700 hrs;
an identified date – missing documentation from 1500 – 2230 hrs;
two identified dates – missing documentation from 0730 – 1430 hrs;
an identified date – missing documentation for full 24 hour period from 0730 – 0700 hrs;
an identified date – missing documentation from 1500 – 2230 hrs;
an identified date – missing documentation from 0730 – 2100 hrs;
an identified date – missing documentation from 0730 – 2230 hrs; and 0200 – 0700 hrs;
an identified date – missing documentation from 2300 – 0700 hrs;
an identified date – missing documentation from 1500 – 2300 hrs;
an identified date – missing documentation from 1400 – 1430 hrs; and
an identified date– missing documentation from 0730 – 1430 hrs; and 2300 – 0700 hrs.

Together with Inspector #621, RPN #111 reviewed the DOS record from a specific date range, and identified that the DOS record was to be completed by PSW staff in 30 minute intervals, and confirmed that the record had missing documentation for the identified dates and times, over the two week monitoring period. RPN #111 further reported that the DOS documentation had been started on resident #004 as a consequence of the altercation between them and resident #003 on an identified date, in order to more closely monitor their behaviours.

During an interview with the Regional Director for Extendicare Assist #109, they reported to the Inspector that the home had completed education on the responsive behaviour management policies earlier in the year, as there had been incomplete documentation issues identified previously. They further stated, that it was their expectation that PSWs completed the DOS record documentation, and that DOS records were completed in full.

CO #002 was issued during inspection # 2019_746692_0019 pursuant to the O.Reg 79/10, s. 53. (4) with a compliance due date of September 30, 2019. As the compliance date was not yet due at the time of this inspection, this finding will be issued as a WN to further support the order. [s. 53. (4)]

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act**

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

**s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:**
**2. A description of the individuals involved in the incident, including,**
**i. names of all residents involved in the incident,**
**ii. names of any staff members or other persons who were present at or discovered the incident, and**
**iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).**

**Findings/Faits saillants :**

1. In making a report to the Director under subsection 23(2) of the Act, the licensee failed to have included the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone, or neglect of a resident by the licensee or staff that led to the report: A description of the individuals involved in the incident, including names of staff members or other persons who were present at or discovered the incident.

A CIS report was received by the Director on an identified date, concerning suspicions of staff to resident neglect of resident #001 on a previous date.

On review of the CIS report, Inspector #621 identified that the report had not indicated the full name and designation of the staff member suspected of neglecting the resident.

During an interview with CM #107, they had acknowledged that PSW #106 had been involved in the incident on an identified date; that they had documented only the PSW's designation in the CIS report, and that they should have included PSW #106's first and last name in the CIS report, but did not. [s. 104. (1) 2.]

**Issued on this 11th day of October, 2019**

**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**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | MELISSA HAMILTON (693), DEBBIE WARPULA (577), JULIE KUORIKOSKI (621) |
| **Inspection No. / No de l'inspection :** | 2019_768693_0021 |
| **Log No. / No de registre :** | 013476-19, 013549-19, 013795-19, 015374-19, 015440-19, 015539-19, 015542-19, 015650-19 |
| **Type of Inspection / Genre d'inspection:** | Critical Incident System |
| **Report Date(s) / Date(s) du Rapport :** | Sep 18, 2019 |
| **Licensee / Titulaire de permis :** | St. Joseph's Care Group<br>35 North Algoma Street, THUNDER BAY, ON, P7B-5G7 |
| **LTC Home / Foyer de SLD :** | Hogarth Riverview Manor<br>300 Lillie Street, THUNDER BAY, ON, P7C-4Y7 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Sheila Clark |

Ontario

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l’inspecteur

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

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

Ontario

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

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

**Order(s) of the Inspector**

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

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

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

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**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. (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).

**Order / Ordre :**

The licensee must be in compliance with s. 6. (7) of the LTCHA. Specifically the licensee
must:
a) Ensure resident #001's and all other resident's plans of care are followed specifically, but not limited to personal care and monitoring checks.

b) Ensure resident #005's and all other resident's plans of care are followed specifically, but not limited to falls prevention interventions.

c) Maintain a record of the actions taken to address the above items.

**Grounds / Motifs :**

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

A CIS report was received by the Director on an identified date, concerning suspicions of staff to resident neglect of resident #001, by PSW #106, on another identified date. The CIS report identified the resident's substitute decision maker (SDM) brought forward concerns to Clinical Manager #107, that personal care for resident #004 had not been provided; the SDM reported that they had found the resident, with specified evidence that care had not been provided when they arrived to the home that morning.

A review of the home's investigation notes contained an interview, from an identified date, by Clinical Manager #107 with PSW #106, which identified that PSW #106 confirmed they had not checked resident #001 on the morning of the incident; and had not reviewed the resident's care plan. Additionally,

documentation of video footage from the identified date, identified that resident #001 had been redirected back to their room at a specified time, and did not leave their room until an identified number of hours later. Additionally, video footage documentation found no PSW had entered into the resident's room for a period of approximately seven hours, between a specified time period. The investigation record also identified a letter of counsel addressed from the home to PSW #106, on an identified date, which indicated that the PSW did not review or follow the resident's plan of care, with respect to this incident.

Inspector #621 reviewed resident #001's care plan in effect at the time of the incident, which identified the following:
- Under specified foci, the care plan identified individualized care that staff were to provide to the resident.

During interviews with PSW #115 and RPN #116, they reported to Inspector #621 that resident #001 usually experienced continence concerns at a specific time of day and required an identified level of assistance with personal care. PSW #115 and RPN #116 further identified that identified care for the resident usually consisted ofspecified personal care, and provision of an identified meal.

During an interview with CM #107, they reported to the Inspector that PSW #106 was found on the specific shift of an identified date, to have not provided any monitoring checks, or personal care to resident #001, as per their plan of care. [s. 6. (7)] (621)

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

A CIS report was received by the Director on an identified date, concerning suspicions of staff to resident neglect of resident #001, by PSW #106, on another identified date. The CIS report identified the resident's substitute decision maker (SDM) brought forward concerns to Clinical Manager #107, that personal care for resident #004 had not been provided; the SDM reported that they had found the resident, with specified evidence that care had not been provided when they arrived to the home that morning.

A review of the home's investigation notes contained an interview, from an

identified date, by Clinical Manager #107 with PSW #106, which identified that PSW #106 confirmed they had not checked resident #001 on the morning of the incident; and had not reviewed the resident's care plan. Additionally, documentation of video footage from the identified date, identified that resident #001 had been redirected back to their room at a specified time, and did not leave their room until an identified number of hours later. Additionally, video footage documentation found no PSW had entered into the resident's room for a period of approximately seven hours, between a specified time period. The investigation record also identified a letter of counsel addressed from the home to PSW #106, on an identified date, which indicated that the PSW did not review or follow the resident's plan of care, with respect to this incident.

Inspector #621 reviewed resident #001's care plan in effect at the time of the incident, which identified the following:
- Under specified foci, the care plan identified individualized care that staff were to provide to the resident.

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During an interview with CM #107, they reported to the Inspector that PSW #106 was found on the specific shift of an identified date, to have not provided any monitoring checks, or personal care to resident #001, as per their plan of care. [s. 6. (7)]

The decision to issue a Compliance Order (CO) was based on the severity of this issue which was determined to be a level three, as there was actual harm. The scope of the issue was a level two, as this was determined to be a pattern in the home. In addition, the home's compliance history identified an ongoing history of non-compliance specific to this area of the legislation. The home has a history of non-compliance in this area of the legislation as follows:
- a Voluntary Plan of Correction (VPC) was issued from a Complaint Inspection #2019_746692_0018, on August 20, 2019;
- a VPC was issued from a Complaint Inspection #2018_624196_0030, on

December 20, 2018;
- a Compliance Order (CO) was issued from a Resident Quality Inspection (RQI) #2018_633577_0006, on May 24, 2018;
- a Written Notification (WN) was issued from a Compliant Inspection #2018_655679_0005, on March 22, 2018;
- a WN was issued from a Compliant Inspection #2018_657681_0002, on February 2, 2018;
- a VPC was issued from a Complaint Inspection #2017_509617_0020, on November 14, 2017;
- a CO was issued from a Follow Up Inspection #2017_616542_0002, on February 28, 2017; and
- a CO with a Director's Referral (DR) was issued from a Follow Up Inspection #2016_391603_0024, on November 25, 2016. (577)

**This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le :** Nov 29, 2019

Ontario

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

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

## Order(s) of the Inspector

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

## Ordre(s) de l'inspecteur

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

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**Order # / Ordre no :** 002

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:

1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required.
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition.
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

**Order / Ordre :**

The licensee must be compliant with s. 30. (1) of Ontario Regulation 79/10. The licensee shall ensure that the following is complied with in respect to each of the organized programs required under section 8 to 16 of the Act, and each of the interdisciplinary programs required under section 48 of Ontario Regulation 79/10. Specifically the licensee must:

a) Ensure that the Continence Care and Bowel Management Program, Falls Prevention and Management Program, and all other organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of the Regulation are evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

b) Maintain a record of the actions taken to address the above items.

**Grounds / Motifs :**

1. The licensee has failed to ensure that the following was complied with in respect to each of the organized programs required under section 8 to 16 of the Act, and each of the interdisciplinary programs required under section 48 of Ontario Regulation 79/10.

Specifically, the licensee has failed to ensure that the Continence Care and Bowel Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A CIS report was received by the Director on August 8, 2019, concerning suspicions of staff to resident neglect of resident #001 on an identified date, with respect to identified areas of care.

A review of the home's policy titled "Continence Care and Bowel Management Program, LTC 3-70", as provided to Inspector #621 by Clinical Manager #107 on September 3, 2019, it was noted that the program policy was dated from March 2016.

During an interview with CM #107, they informed the Inspector that the home had not yet implemented Extendicare's continence care program policies and

procedures, and that the home's policy equivalent, which was still being utilized, was more than a year old.

During an interview with the Administrator on Sept 3, 2019, they confirmed that the home was still rolling out education and implementation of the Extendicare continence care program, and that at the time of inspection, this still had not been completed. Additionally, they stated that it was their expectation that home's continence care program policies and procedures had been reviewed and updated at least annually. [s. 30. (1) 3.]

2. Specifically, the licensee has failed to ensure that the Falls Prevention and Management Program was evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

A CIS report was submitted to the Director, on an identified date, for an incident that caused injury to resident #009, for which the resident was taken to the hospital and resulted in a significant change in the resident's health status. The report further identified that the incident was an unwitnessed fall, and the resident had sustained an injury.

Inspector #693 reviewed the home's policy, titled, "Falls Management, LTC 3-60" as provided to Inspector #577, by The Extendicare Assist Regional Director #109. It was noted that the program policy indicated that the home adopted the Extendicare Policy on December 18, 2017. Inspector #693 reviewed the policy and noted that the attached Extendicare program policy, titled, "Falls Prevention and Management Program, RC-15-01-01", was last updated in February 2017.

During an interview with the Administrator, they stated they assumed that Extendicare had an updated Falls Prevention policy, but that the home may not have implemented the most recent policy yet, and that they would confirm this and get back to the Inspector. The Administrator, later confirmed to Inspector #577, that the home's Falls Prevention and Management Program and policy that was in use was implemented in the home on December 18, 2017, and approved by the St Joseph's Care Group, Seniors Health Quality Safety and Risk Committee on March 21, 2018. The Administrator stated that the home was using a policy that was not updated within the last year, for the Falls Prevention

and Management Program.

During and interview with the Extendicare Assist LTC Consultant, they indicated that they knew that the home had not fully implemented Extendicare policies, and that Extendicare's the Falls Prevention and Management Program was last updated in June, 2019. They stated that they would confirm with DOC #105, when the Falls Prevention and Management Program would be implemented in the home.

During an interview with DOC #105, they stated that they, together with the VP of Seniors Health, created a schedule with prioritization for implementing all Extendicare policies. The DOC stated that the Falls Prevention and Management program was out of date as it had not been reviewed in the last year, and that the home planed to update and review the policy to match Extendicare's Falls Prevention Program, last updated in June, 2019 in the near future. [s. 30. (1) 3.]

The decision to issue a Compliance Order (CO) was based on the severity of this issue which was determined to be a level two, as there was minimal harm or risk of harm. The scope of the issue was a level two, as this was determined to be a pattern in the home. In addition, the home's compliance history identified a history of non-compliance specific to this area of the legislation. The home has a history of non-compliance in this area of the legislation as follows:
- a Voluntary Plan of Correction (VPC) from a Critical Incident System (CIS) Inspection #2019_740621_0020, on July 3, 2019. (693)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 29, 2019

**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

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**Order # / Ordre no :** 003

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

**Order / Ordre :**

The licensee must be compliant with s. 36. of Ontario Regulation 79/10. The licensee shall ensure that staff used safe transferring and positioning devices or techniques when assisting residents. Specifically the licensee must:

a) Ensure that staff use safe transferring and positioning devices or techniques when assisting resident #008, and all other residents.

**Grounds / Motifs :**

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

A CIS report was submitted to the Director on an identified date, concerning resident #008 who had fallen and sustained an injury. The report indicated that the resident had received morning care from PSW #120, and when they had turned away from the bedside, the resident fell and sustained an injury.

A review of resident #008's care plan in place at the time of the fall, identified that resident #008 required assistance from a specified number of staff members.

A review of the home's incident report identified that resident #008 had received morning care from PSW #120, where they had the bed at waist level and had positioned an intervention; PSW #120 reported that they had turned around to place an item into the garbage and the resident fell. The resident was transferred to acute care for further assessment and had been diagnosed with an identified injury.

A review of the investigation notes identified a letter from an identified date, from CM #107 to PSW #120. The letter indicated that PSW #120 had not followed the care plan in regards to bed mobility, continence, bathing and transferring. Further, it was expected that they would have the appropriate number of staff members present to apply an identified intervention and perform care as per the care plan. Interview notes indicated that after the fall, PSW #120 and another staff member transferred the resident into a chair, after they fell, with an identified transfer method.

During an interview with PSW #120, they reported to Inspector #577 that they had not read resident #008's care plan that day and had performed all of their care without assistance. The PSW reported they were not aware that they were not to position an identified intervention under a resident without assistance.

A review of the home's, "Safe Lifting With Care Program- LTC-5-110", revised March 21, 2018, indicated that two trained staff were required at all times when they performed a mechanical lift., two staff were required to position the sling underneath the resident and centering the resident within the sling.

During an interview with CM #107, they reported that PSW #120 had not followed the mechanical lift policy and had not followed resident #008's plan of care. [s. 36.]

The decision to issue a Compliance Order (CO) was based on the severity of this issue which was determined to be a level three, as there was actual harm. The scope of the issue was a level one, as this was determined to be an isolated occurrence. In addition, the home's compliance history identified an ongoing history of non-compliance specific to this area of the legislation. The home has a history of non-compliance in this area of the legislation as follows:
- a Voluntary Plan of Correction (VPC) was issued from a Complaint Inspection #2019_633577_0010, on June 4, 2019;
- a VPC was issued from a Complaint Inspection #2018_624196_0023, on October 11, 2018;
- a Written Notification (WN) was issued from a Critical Incident System (CIS) Inspection #2017_509617_0023, on January 5, 2018; and
- a CO was issued from a CIS Inspection #2017_509617_0017, on October 11, 2017. (693)

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

**This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le :** Nov 04, 2019

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

## 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 18th day of September, 2019**

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

**Name of Inspector /**
**Nom de l'inspecteur :** Melissa Hamilton

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