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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Feb 11, 2014	2013_205129_0015	H-000594-13	Complaint

Licensee/Titulaire de permis

REGENCY LTC OPERATING LP ON BEHALF OF REGENCY
100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1

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

THE WATERFORD
2140 Baronwood Drive, OAKVILLE, ON, L6M-4V6

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

PHYLLIS HILTZ-BONTJE (129)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): October 9, 17, 21, 22, 24 and 25, 2013

During the course of the inspection, the inspector(s) spoke with resident's substitute decisions makers, regulated and unregulated nursing staff, the Director of Care and the Administrator in relation to log #H-000594-13.

During the course of the inspection, the inspector(s) observed residents and care being provided to residents, reviewed clinical record documents, reviewed training schedules and attendance records and reviewed home policies (Palliative, Pain and symptom control as well as three policies/procedures that make up the home's Skin and Wound Care Program).

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Skin and Wound Care

Findings of Non-Compliance were found during this inspection.

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee did not ensure that the care set out in the plan of care was provided to residents as specified in the plan in relation to the following: [6(7)]
a) Resident #002's plan of care directed staff to assist the resident to turn and reposition every two hours while in bed. This care was not provided as specified in the resident's plan of care on an identified date when the resident was monitored and it was noted that staff did not assist the resident to turn and reposition for a period of time in excess of two hours.
b) Resident #003's plan of care directed staff to turn and reposition the resident every two hours while in bed. This care was not provided as specified in the plan of care on an identified date when the resident was monitored and it was noted that staff did not assist the resident to turn and reposition for a period of time in excess of two hours.
c) Resident #004's plan of care directed staff to turn and reposition the resident every two hours. This care was not provided as specified in the plan of care when on an identified date the resident was monitored and it was noted that staff did not assisted the resident to turn and reposition for a period of time in excess of two hours. [s. 6. (7)]

Additional Required Actions:

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

WN #2: 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 protect resident #001 from neglect by staff in relation to the following: [19(1)]
Resident #001 developed three pressure wounds and one wound that was not related to pressure while in the care of the home. Inaction by staff related to infection control, wound management and the management of risks related to hydration jeopardized the resident's health and resulted in the resident being transferred to hospital for assessment and treatment of sepsis from wound infections and dehydration. This pattern of inaction [redacted] jeopardized the well-being of the resident
The licensee did not take action to protect this resident from neglect when:
- The licensee did not ensure that all staff who provide direct care to residents had the knowledge and skill to provided skin and wound care when it was confirmed that not all staff who provided direct care to residents received annual training in the area of skin and wound care in 2012.
- The licensee did not ensure that care identified as being required by this resident was provided as specified in the plan of care. Registered staff confirmed that they did not monitor that care identified as required related to turning and positioning was actually provided to the residents.
- Staff confirmed that there was not a system or mechanism implemented in the home to ensure the interdisciplinary team met to review the care being provided to residents with wounds that were not healing in order that prompt action was taken to ensure different approaches to care were initiated. [s. 19. (1)]

May 11, 2015
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Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee did not ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was reassessed at least weekly by a member of the registered nursing staff, in relation to the following: [50(2)(b)(iv)]
a) Clinical documentation indicated Resident # 001 had four wounds. Staff and clinical documentation confirmed that these wounds were not assessed weekly.
- Wound #2 was assessed on May 10, 2013 and documentation identified there was eschar in the wound base, assessed again 12 days later on May 23, 2013 when the wound was noted to be larger in size, contained eschar in the wound base, and was noted to be draining a moderated amount of fluid. There were no further weekly wound assessment completed until July 9, 2013 when the wound was identified as containing necrotic tissue, was red and warm to touch and had an odour.
- Wound #3 was assessed on May 10, 2013 and documentation identified there was eschar in the wound base, assessed again 12 days later on May 23, 2013 where it was identified as being larger in size, moist, containing eschar in the wound base and was draining a moderate amount of fluid. There were no further weekly wound

assessments completed until July 9, 2013 when it was noted that there was an odour about the wound and the area around the wound was red and warm to the touch.
- Wound #4 was assessed on June 29, 2013, assessed again on July 5, 2013 indicating the wound had increased in length. The next weekly assessment was completed 14 days later and indicated the wound was healed.
- Wound #1 was assessed on June 7, 2013 and was identified as having eschar in the wound base and the area around the wound was noted to be red and warm to the touch. The following assessment, completed 10 days later indicated that there continued to be eschar in the base of the wound and the area around the wound continued to be red and warm to the touch. The following assessment completed 15 days later indicated the wound had increased in size, continued to contain eschar in the wound base, was red and warm to touch and there was an odour about the wound.
b) Clinical documentation indicated Resident #002 had two wounds, but did not have weekly skin and wound assessments completed. Staff and clinical documentation confirmed that there were two weekly wound assessments completed on August 16 and 28, 2013, there were four wound assessments in September that were not completed within seven day periods of each other and there were two wound assessments completed on October 8 and 22, 2013
c) At the time of this inspection resident #003's plan of care indicated that the resident had a one wound. Staff and clinical documentation confirmed that weekly wound assessments were not completed. The last skin assessment of this wound was completed on September 15, 2013, 24 days prior to the first day of this inspection. [s. 50. (2) (b) (iv)]

2. The licensee did not ensure that any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required, in relation to the following: [50(2)(d)]
a) Resident #002's care plan indicated the resident was dependent on staff for repositioning; however the resident was not repositioned for a period of time in excess of two hours.
On an identified date the resident was noted to be in bed and in a side lying position at 1415hrs. The resident was monitored through to 1630hrs and it was noted that the resident's position in bed had not been change over this period of time. At the time of this inspection the resident was identified as having a wound that was acquired while in the home. Staff confirmed that this resident was dependent on staff for repositioning and the plan of care indicated that the resident required the assistance of one staff for bed positioning.

b) Resident #003's plan of care indicated the resident was dependent on staff for repositioning; however, the resident was not repositioned for a period of time in excess of two hours on an identified date. The resident was noted to be lying on the left side in bed at 1000hrs. The resident was monitored through to 1215hrs and it was noted that the resident's position had not changed over this period of time. At the time of this inspection the resident was noted to have a wound that was acquired while in the home. Staff confirmed that this resident was dependent on staff for positioning and the plan of care indicated the resident required staff to provided total assistance for bed mobility.
c) Resident #004 was dependent on staff for repositioning and was not repositioned for a period of time in excess of two hours. On an identified date at 0945hrs. the resident was noted to be in the hallway sitting in a wheelchair that was in the maximum back tilt positioned. A short time later the resident was noted to be in the same position in the wheelchair, and at this time the resident's upper body was leaning to the left side and the resident was noted to be sleeping. At 1000hrs staff moved the resident in the wheelchair into the bedroom, placed a blanket over the resident, but did not change the resident's position. The resident was monitored through to 1210hrs. and it was noted that the resident's position had not changed. Staff confirmed that this resident was not able to independently change position, the resident's plan of care indicated that the resident required the use of a mechanical lift for transferring and also required total assistance of two staff to turn and position. [s. 50. (2) (d)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee did not ensure that resident #001's right not to be neglected was the fully respected and promoted, in relation to the following:[3(1)3]

1. Inaction by staff related to wound assessment, evaluation of the effectiveness of care being provided, revising the plan of care when it was identified that care being provided to the resident was not effective, ensuring directions for care were accurate and complete as well as monitoring of care being provided to resident #001 resulted in this resident experiencing ongoing wound infections and poor wound healing.

a) Clinical documentation indicated wound #1 was reported by staff working nights on an identified date, and was described as an abrasion. Documentation indicated the wound was cleansed and a dressing was applied. The following identifies the sequence of events, related to this wound, over a two month period of time when the resident was transferred to hospital for the treatment of sepsis from infected wounds:
-Staff working the day shift on May 30, 2013 identified this wound had increased in size. Staff did not complete an assessment of this wound and did not identify the possible cause of this injury in order to reduce the risk of further injury to the resident. There was no evidence in the clinical record that a treatment plan had been developed in related to the management of this wound. Staff interviewed at the time of this inspection indicated that in the past wounds in the home were assessed and managed by an Enteralstomal Nurse (ET) who visited the home through a contract with the Community Care Access Centre; however this service was no longer available and staff lacked the confidence and experience to assess and manage wounds.
-Five days after the initial report of this injury staff completed a weekly skin and wound assessment for this wound and indicated there was eschar in the wound base and the skin area around the wound was red and warm to the touch. Documentation on this assessment form indicated that staff did not take a swab of the area, despite signs of a possible infection. On this same day the physician ordered a dressing containing iodosorb was to be applied and this dressing was to be changed three times a week. The physician order the resident to receive oral antibiotics based on the signs of a possible wound infection.
-Four days later, staff completed a weekly skin and wound assessment. This assessment indicated there had been no change in the wound. There was no documentation in the clinical record to indicate that staff took any action when it appeared the treatment plan was not effective in cleaning the wound base or addressing the signs and symptoms of infection.
-Three days later, the physician documented in the clinical record indicating the

antibiotic being given to the resident was to be changed and the resident was to receive this antibiotic for a two week period. The physician also requested a referral to a wound specialist, that the resident be placed on a specialized mattress designed to reduce pressure on the resident's skin and ordered a specialized examination to confirm a suspicion that reduced blood flow was contributing to poor wound healing. A Personal Support Worker (PSW) interviewed at the time of this inspection confirmed that the resident's legs would have remained in a dependent position for long periods of time during the day. Staff identified the resident's daily routine consisted of being assisted into the wheelchair for breakfast, usually remaining in the wheelchair until after lunch, being assisted into bed in the early afternoon, assisted into the wheelchair in the late afternoon for the dinner meal and then remaining in the wheelchair for three or four hours after dinner while visiting with family. Registered staff and clinical documentation confirmed that no care directions were provided to direct care staff in relation to positioning the resident to maximize blood flow and no actions were taken to improve wound healing by ensuring that the affected area was positioned in a way that would maximize the flow of blood, despite the resident's physician indicating this could be a factor in poor wound healing. There was no documentation in the clinical record that a discussion took place regarding the need to change the type of dressing being applied based on staff's documentation that there had been no change in the condition of this wound.

- The following day a Nurse Practitioner (NP) visited the resident in response to the physician's order that a wound specialist assess the resident. There was no documentation in the clinical record of the appearance of the wound as a result of this assessment. The NP documented that decreased pulses where noted confirming that there were barriers to blood supply in the affected area and ordered that the resident be repositioned every hour in order to reduce pressure on the resident's skin and improve wound healing. Staff and clinical documentation confirmed that care directions for the resident were not changed based on directions from the NP that the resident be repositioned every hour and directions in the documents that the home used to describe the care to be provided to the resident indicated that resident was to be repositioned every two to three hours. Registered staff indicated that they were unable to verify that the resident was being repositioned hourly and confirmed that they did not monitor the care being provided by the direct care staff, despite indications that this resident's wound was not healing.

-Two days later a second NP assessed the resident and ordered that the wound was to be painted with betadine, a non-adherent dressing be applied and increased the frequency of dressing changes to daily. Staff did not complete a weekly skin and wound assessment scheduled for June 14, 2013. There was no documentation in the

clinical record indicating the status of the wound or if the current treatment plan was effective in moving towards the goal of care identified in the resident's care plan that the wound would heal and no indication if the antibiotic medication ordered on was effective in managing the wound infection.
-Seven days later two NP's visited the resident and attempted to perform the specialized diagnostic procedure the physician had ordered on June 10, 2013 to determine if diminished blood flow was contributing to poor wound healing. Clinical documentation indicated that the procedure was not completed due to resistance on the part of the resident.
-Four days later staff completed a weekly skin and wound assessment and indicated the condition of the wound had not changed. Documentation on this assessment form indicated the wound base contained eschar and the area around the wound remained red and warm to touch. The resident's course of treatment with antibiotics was about to finish and there was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan when staff continued to document that the condition of the wound had not changed.
-The following day the physician documented in the clinical record that this wound was deteriorating; however, there were no changes to the treatment plan either in relation to dressing the wound or infection control management. Care directions for staff identified in the care plan were not altered and those directions remain the same as were originally identified on June 8, 2013
-Four days later staff documented in the clinical record that the wound was deteriorating; however, the specific appearance of the wound was not documented. Staff also indicated that the physician would assess the wound in 10 days. No action was taken to address the deteriorating condition of this wound.
-Staff did not complete a scheduled weekly skin and wound assessment on June 30, 2013.
-Eight days after staff continued to document that this wound was deteriorating; the NP assessed the wound and noted a small amount of wound drainage and an area of eschar in the centre of the wound. A swab of the wound drainage was obtained and the wound was identified as stage 4 wound. Later the same day staff documented that the dressing was changed and indicated the ongoing presence of infection in the wound when it was documented that the wound was now producing purulent drainage. Staff also documented that the wound swab taken by the NP earlier in the day was destroyed because the laboratory indicated the swab would not remain viable over the weekend. The clinical record indicated there were no changes made in the treatment plan for this wound at this time.
-The following day staff documented that the dressing was changed and there was

now a moderate amount of purulent drainage as well as a foul odour was noted from the wound. Clinical documentation indicated there were no changes made to the treatment plan for this wound at this time.
-The following day staff indicated the resident's condition had deteriorated and the resident now had an increased temperature, for which the resident was given medication designed to reduce temperature. Staff also indicated a wound swab was taken. On this same day the physician documented a note indicating the wound was not doing well with no signs of healing and ordered the resident to begin treatment with another antibiotic for a two week period and the wound dressing was to remain the same as was originally ordered 26 days previously.
- The following day staff completed a weekly skin and wound assessment and indicated the wound continued to deteriorate when they documented that the wound was now double the length, slightly wider, was moist, eschar was noted in the base, there was a foul odour about the wound and the area around the wound remained warm to the touch. A diagnostic procedure of the affected area was completed.
-Two days later, the physician indicated a discussion was held with the resident's Power of Attorney (POA) with respect to the results of the diagnostic procedure. The results indicated a significant blockage of the flow of blood in the affected area. There were no changes to the plan of care related to positioning the resident in order to maximize blood flow and the resident continued to sit in a wheelchair for long periods of time during the day.
-The following day staff completed a weekly skin and wound assessment, another weekly skin and wound assessment seven days later and a third weekly skin assessment seven days later. Documentation on all of these assessments indicated that the wound continued to be moist, contained eschar in the wound base, had a foul odour and the area around the wound was red and warm to touch. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience wound infection and poor wound healing.
-Staff did not complete a weekly skin and wound assessment that was scheduled on August 2, 2013. Two days later staff completed a weekly skin a wound assessment that indicated the resident's wound continued to deteriorate when they documented that the wound now contained a moderate amount of bloody discharge. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience wound infection and poor wound healing.

-Four days later, the resident's POA expressed concern about the resident's condition and requested the resident be placed on antibiotics to combat infection. Staff approached a NP who was seeing other residents in the home and requested the resident be assessed. The NP assessed the resident as possibly having a systemic infection related to ongoing wound infection, identified the resident as being dehydrated and ordered the resident to be transferred to hospital for assessment and treatment.
-Documentation provided by the home at the time of this inspection indicated that not all staff who provide direct care to residents had received training in relation to skin and wound care.
-Staff did not follow directions contained in the home's skin and wound policy when providing care to resident #001.
-Staff did not complete weekly wound assessments.
-Staff in the home did not ensure that resident #001's plan of care included information to PSWs providing basic care when there were not directions for positioning the resident, there were inaccurate directions for the turning and positioning schedule for this resident and there was no information with respect to wound infections and directions for staff related to hygiene/bathing needs.
-Registered staff confirmed that care being provided to the resident by PSWs was not monitored in order to ensure the care identified related to turning and positioning the resident was provided.
-In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff in relation to the management of this wound jeopardized resident #001's health and well-being. This inaction contributed to poor wound healing and ongoing wound infection [redacted]. The resident was transferred to hospital for assessment and management of sepsis and poor wound healing and died in hospital.

May 11, 2015
P. H Brodie

b) Wound #3 was identified when staff completed a weekly skin and wound assessment for this wound and indicated the wound was 0.8cm. x 1.0cm, the wound was dry and there was eschar in the base of the wound. There was no evidence in the clinical record related to the plan of care for the management of this wound. The following identifies the sequence of events, related to this wound, over a three month period of time up until the resident was transferred to hospital for the treatment of sepsis from infected wounds:
-Thirteen days after staff identified this wound the NP ordered staff to continue to cover the area with foam dressing to help with drainage and staff were to monitor for any additional similar wounds. Documentation by the NP indicated that since the last

assessment 13 days ago this wound had deteriorated and now there was drainage from the wound that required a dressing that was designed to manage drainage. On this same day staff completed a weekly skin and wound assessment and indicated that the wound had increased in size, that the wound was moist and there was eschar in the wound base. Although the NP saw the resident on this day there were no changes to the treatment plan for this wound, despite the wound increase in size and the change in character of the wound.
- Staff did not complete a weekly skin and wound assessment on May 30, 2013 and there was no current information in the clinical record with respect to the condition and appearance of this wound.
- On June 3, 2013 staff documented that this wound dressing was changed following a shower; however there was no indication that an assessment of the wound was completed and there was no documentation related to the appearance and condition of the wound. On this same date the physician ordered the resident to receive antibiotics; however there is no indication that the physician assessed this wound.
- Staff did not complete a weekly skin and wound assessment on June 6, 2013.
- On June 7, 2013 staff documented that the dressing over this wound was changed; however there is no evidence that an assessment was completed. The last documentation related to the condition and appearance of this wound was entered into the clinical record 16 days previously.
- Three days later, the physician documented in the clinical record indicating the antibiotic being given to the resident was to be changed and the resident was to receive this antibiotic for a two week period. The physician also requested a referral to a wound specialist, that the resident be placed on a specialized mattress designed to reduce pressure on the resident's skin and ordered a specialized examination to confirm a suspicion that reduced blood flow was contributing to poor wound healing. A Personal Support Worker (PSW) interviewed at the time of this inspection confirmed that the affected area would have remained in a dependent position for long periods of time during the day. Staff identified the resident's daily routine consisted of being assisted into the wheelchair for breakfast, usually remaining in the wheelchair until after lunch, being assisted into bed in the early afternoon, assisted into the wheelchair in the late afternoon for the dinner meal and then remaining in the wheelchair for three or four hours after dinner while visiting with family. Registered staff and clinical documentation confirmed that no care directions were provided to direct care staff in relation to positioning the resident to maximize blood flow and no actions were taken to improve wound healing by ensuring the affected area was positioned in a way that would maximize the flow of blood, despite the resident's physician indicating this could be a factor in poor wound healing. There was no documentation in the clinical record

that a discussion took place regarding the need to change the type of dressing being applied based on staff's documentation that there had been no change in the condition of this wound. Clinical documentation indicated that there was no current information about the condition or appearance of this wound since it was last documented 19 days ago and there had been no changes made to the treatment plan for this wound.
- A day after the physician documented in the clinical record a Nurse Practitioner (NP) visited the resident in response to the physician's order that a wound specialist assess the resident. There was no documentation in the clinical record of the appearance of the wound as a result of this assessment. The NP documented that decreased pulses where noted in the affected area confirming that there were barriers to blood supply to the affected area and ordered that the resident be repositioned every hour in order to reduce pressure on the resident's skin and improve wound healing. Staff and clinical documentation confirmed that care directions for the resident were not changed based on directions from the NP that the resident be repositioned every hour and directions in the documents that the home used to describe the care to be provided to the resident indicated that resident was to be repositioned every two to three hours. Registered staff indicated that they were unable to verify that the resident was being repositioned hourly and confirmed that they did not monitor the care being provided by the direct care staff, despite indications that this resident's wound was not healing.
- The following day the NP noted in the clinical record that wound #2 measured 3.5cm x 2cm, there was black eschar in the wound base, identified this wound as a stage II wound, identified that pedal pulses are decreased and there was pitting edema in the area. The NP ordered a change in the wound treatment and the wound was be painted with betadine, a non-adherent dressing be applied, the resident was be repositioned every hour and requested a referral to the Occupational Therapist (OT) related to off-loading of pressure to the affected area.
- The following day the OT documented that it was recommended that the resident have a pillow between the thighs when in bed and between feet to minimize rubbing.
- Staff did not complete a weekly skin and wound assessment on June 13, 2013.
- Five days after the NP saw the resident staff documented in the progress notes that the wound seemed to be improving, but do not document the condition or appearance of the wound.
- Staff did not complete a weekly skin and wound assessment on June 20 or 27, 2013
- There was no evidence in the clinical record that staff assessed the effectiveness of the antibiotic treatment ordered seventeen days prior, in reducing the signs of a possible infection in this wound.
- The NP visited the resident 24 days after the last visit and ordered that staff were to

continue with the current dressing orders, but did not specify which wounds this direction applied to. There was no current information about the condition and appearance of this wound since the last documentation 24 days ago.
- Two days later staff indicated the resident's condition has deteriorated and the resident now had an increased temperature, for which the resident was given medication designed to reduce temperature. Staff also indicated a swab was taken from wound #1. On the same day the physician ordered the resident to begin treatment with another antibiotic for a two week period; however did not indicate wound #2 was assessed.
- The following day staff completed a weekly skin and wound assessment and indicated the wound was identified as a stage II wound, was moist, there was an door about the wound and the area around the wound was red and warm to the touch.
- Three days later staff completed a weekly skin and wound assessment indicating there was a slight increase in the size of the wound and the wound continued to be moist, odour was present and the skin around the wound remained red and warm to touch. There was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan when staff identified the presence of ongoing infection and poor wound healing.
-Seven days later staff completed a weekly skin and wound assessment and indicated the size of the wound had not changed, the wound continued to be moist, necrotic tissue was noted in the base, there continued to be an odour about the wound and the skin around the wound remained warm to touch. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered, despite the resident continuing to experience a wound infection and a deteriorating condition of this wound.
- There was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan following a course of antibiotics ordered 11 days ago. Staff continued to document signs and symptoms of a wound infection when it was documentation indicated there was an odour about the wound and the area around the wound was red and warm to touch.
- Three days after the last skin assessment the physician ordered that staff were to continue to paint the wound with betadine, but did not make a note about the condition or appearance of this wound.
- Staff completed a weekly skin and wound assessment four days later indicating there had been a slight increase in the size of the wound, the wound remained moist, there was an odour about the wound and the area around the wound was red and warm to touch. The clinical record confirmed that there were no changes made to the plan of care for this wound

- Sixteen days after the last assessment staff complete a weekly skin and wound assessment indicating there had been no change in the wound and the wound continued to have an odour, the skin around the wound remains red and warm to touch. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience wound infection and poor wound healing.
- Four days later the resident's POA expressed concern about the resident's condition and requested the resident be placed on antibiotics to combat infection. Staff approached a NP who was seeing other residents in the home and requested the resident be assessed. The NP assessed the resident as possibly having a systemic infection related to ongoing wound infection, identified the resident as being dehydrated and ordered the resident to be transferred to hospital for assessment and treatment.
- Documentation provided by the home at the time of this inspection indicated that not all staff that provide direct care to residents had received training in relation to skin and wound care.
- Staff did not follow directions contained in the home's skin and wound policy when providing care to resident #001.
- Staff did not complete weekly wound assessments.
- Staff in the home did not ensure that resident #001's plan of care included information to PSWs providing basic care when there were not directions for positioning the resident, there were inaccurate directions for the turning and positioning schedule for this resident and there was no information with respect to wound infections and directions for staff related to hygiene/bathing needs.
- Registered staff confirmed that care being provided to the resident by PSWs was not monitored in order to ensure the care identified related to turning and positioning the resident was provided.
- In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff in relation to the management of this wound jeopardized resident #001's health and well-being. This inaction contributed to poor wound healing and ongoing wound infection[redacted]. The resident was transferred to hospital for assessment and management of sepsis and poor wound healing and died in hospital.

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P. H Bo[illegible]

c) Wound #2, a second wound located in the same area as wound #3 was identified when staff completed a weekly skin and wound assessment and indicated the wound was 0.4cm. x 0.5.cm, the wound was dry and there was eschar in the base of the

wound. There was no evidence in the clinical record related to the plan of care for the management of this wound. The following identifies the sequence of events, related to this wound, over a three month period of time up until the resident was transferred to hospital for the treatment of sepsis from infected wounds:
- Staff did not complete a weekly skin and wound assessment of this wound on May 17, 2013.
- Thirteen days after the identification of this wound the NP ordered staff to continue to cover the wound with a foam dressing to help with drainage and staff were to monitor for any similiar wounds. Documentation by the NP indicated that since the last assessment 13 days ago this wound had deteriorated and now there was drainage from the wound that required a specialized dressing designed to manage drainage. On this same day staff completed a weekly skin and wound assessment and indicated that the wound had increased in size, that the wound was moist and there was eschar in the wound base. Although the NP saw the resident on this day there were no changes to the treatment plan for this wound, despite the increase in size of wound and the change in character of the wound.
- Staff did not complete a weekly skin and wound assessment on May 30, 2013 and there was no information in the clinical record of the condition or appearance of this wound since the last assessment completed seven days prior.
- Eleven days after the previous assessment staff documented that this dressing was changed following a shower; however there is no indication that an assessment of the wound was completed and there has been no documentation related to the appearance and condition of the wound. On this same date the physician ordered the resident to receive antibiotics; however there was no indication that the physician assessed this wound.
- Staff did not complete a weekly skin and wound assessment on June 6, 2013.
- Four days after the last documentation that the dressing over this wound was changed staff again documented that the dressing over this wound was changed; however there was no evidence that an assessment was completed. There was no current information regarding the appearance and condition of this wound since it was last documented 16 days ago.
- Three days later the physician documented in the clinical record indicating the antibiotic being given to the resident was to be changed and the resident was to receive this antibiotic for a two week period. The physician also requested a referral to a wound specialist, that the resident be placed on a specialized mattress designed to reduce pressure on the resident's skin and ordered a specialized examination to confirm a suspicion that reduced blood flow was contributing to poor wound healing. A Personal Support Worker (PSW) interviewed at the time of this inspection confirmed

that the affected area would have remained in a dependent position for long periods of time during the day. Staff identified the resident's daily routine consisted of being assisted into the wheelchair for breakfast, usually remaining in the wheelchair until after lunch, being assisted into bed in the early afternoon, assisted into the wheelchair in the late afternoon for the dinner meal and then remaining in the wheelchair for three or four hours after dinner while visiting with family. Registered staff and clinical documentation confirmed that no care directions were provided to direct care staff in relation to positioning the resident to maximize blood flow and no actions were taken to improve wound healing by ensuring the resident was positioned in a way that would maximize the flow of blood, despite the resident's physician indicating this could be a factor in poor wound healing. There was no documentation in the clinical record that a discussion took place regarding the need to change the type of dressing being applied based on staff's documentation that there had been no change in the condition of this wound. There was no evidence that this wound was assessed, there was no documentation in the clinical record describing the wound and there had been no changes made to the treatment plan for this wound.

- The following day a Nurse Practitioner (NP) visited the resident in response to the physician's order that a wound specialist assess the resident. There was no documentation in the clinical record of the appearance of the wound as a result of this assessment. The NP documented that decreased pulses where noted in the affected area, confirming that there were barriers to blood supply and ordered that the resident be repositioned every hour in order to reduce pressure on the resident's skin and improve wound healing. Staff and clinical documentation confirmed that care directions for the resident were not changed based on directions from the NP that the resident be repositioned every hour and directions in the documents that the home used to describe the care to be provided to the resident indicated that resident was to be repositioned every two to three hours. Registered staff indicated that they were unable to verify that the resident was being repositioned hourly and confirmed that they did not monitor the care being provided by the direct care staff, despite indications that this resident's wound was not healing.
- The following day the NP noted in the clinical record that wound #2 measured 7.0cm x 4.0cm, identified this wound as a stage II wound, identified that pedal pulses were decreased and there was pitting edema in the area. The NP ordered a change in the wound treatment and the wound was to be painted with betadine, a non- adherent dressing be applied, the resident was to be repositioned every hour and requested a referral to the Occupational Therapist (OT) related to off-loading pressure to the affected area.
- The following day the OT documented that it was recommended that the resident

have a pillow between the thighs when in bed and between feet to minimize rubbing.
- Staff did not complete a weekly skin and wound assessment on June 13, 2013.
- Five days after the NP's assessment staff note in the progress notes that this wound seems to be improving, but did not document the condition or appearance of the wound.
- Staff did not complete a weekly skin and wound assessment on June 20 or 27, 2013
- There was no evidence in the clinical record that staff assessed the effectiveness of the antibiotic treatment ordered on June 10, 2013.
- Nineteen days after the last wound assessment was completed the NP ordered that staff were to continue with the current dressing orders, but did not specify which wounds this direction applied to. There was no indication in the clinical record that this wound was assessed at this time and there was no current information about the condition or appearance of this wound since it was last document 24 days ago.
- Two days later staff indicated the resident's condition has deteriorated and the resident now had an increased temperature, for which the resident was given medication designed to reduce temperature. Staff also indicated a wound swab was taken from wound #1. On the same day the physician ordered the resident to begin treatment with another antibiotic for a two week period; however did not indicate wound #2 was assessed and there is no indication of the condition or appearance of this wound in the clinical record.
- The following day staff completed a weekly skin and wound assessment and indicated the wound was 2.0cm x 1.6cm, identified as a stage II wound, the wound was noted to be moist, there was necrotic issue noted, there was an odour about the wound and the area around the wound was red and warm to the touch. There was no documentation in the clinical record to indicate that staff took any action when necrotic tissue was noted in the wound
- Three days later staff completed a weekly skin and wound assessment indicating there was an increase in the size of the wound and the wound continued to be moist, necrotic tissue was noted in the wound, odour was present and the skin around the wound remained red and warm to touch. There was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan when staff identified an increase in the size of the wound, the presence of necrotic tissue, the presence of ongoing infection and poor wound healing.
-Seven days later staff completed a weekly skin and wound assessment and indicated the size of the wound had increased and was now 4.5cm x 2.5, the wound continued to be moist, necrotic tissue was noted in the base, there continued to be an odour about the wound and the skin around the wound remained warm to touch. There was no evidence in the clinical record, including physician orders, progress notes or the

care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience a wound infection and a deteriorating condition of this wound.
- There was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan when the resident's course of antibiotics ordered on July 8, 2013 finished and staff continued to document that there was an odour about the wound and the skin around the wound was red and warm to touch.
- Three days later the physician ordered that staff were to continue to paint the wound with betadine; however, there was no documentation about the condition or appearance of this wound.
- Four days later staff completed a weekly skin and wound assessment indicating there had been no improvement in the condition and appearance of this wound. The clinical record indicated that staff took no action when it appeared the treatment plan was not effective in achieving the goal identified in the plan of care to heal this wound.
-Nine days later staff complete a weekly skin and wound assessment indicating the wound had increased in size to 8.0cm x 4.0c, the wound continued to be moist, contain necrotic tissue, continued to have an odour and the skin around the wound remained red and warm to touch. There is no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience wound infection and poor wound healing.
- Four days later the resident's POA expressed concern about the resident's condition and requested the resident be placed on antibiotics to combat infection. Staff approached a NP who was seeing other residents in the home and requested the resident be assessed. The NP assessed the resident as possibly having a systemic infection related to ongoing wound infection, identified the resident as being dehydrated and ordered the resident to be transferred to hospital for assessment and treatment.
- Documentation provided by the home at the time of this inspection indicated that not all staff who provided direct care to residents had received training in relation to skin and wound care.
- Staff did not follow directions contained in the home's skin and wound policy when providing care to resident #001.
- Staff did not complete weekly wound assessments.
- Staff in the home did not ensure that resident #001's plan of care included information to PSWs providing basic care when there were not directions for positioning the resident, there were inaccurate directions for the turning and

positioning schedule for this resident and there was no information with respect to wound infections and directions for staff related to hygiene/bathing needs.
- Registered staff confirmed that care being provided to the resident by PSWs was not monitored in order to ensure the care identified related to turning and positioning the resident was provided.
- In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff in relation to the management of this wound jeopardized resident #001's health and well-being. This inaction contributed to poor wound healing and ongoing wound infection [redacted]. The resident was transferred to hospital for assessment and management of sepsis and poor wound healing and died in hospital on August 24, 2013.

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2.Inaction by staff in the assessment of risk factors associated with dehydration that were being demonstrated by the resident and in the review and revision of the plan of care for resident #001 when this resident's care needs changed resulted in the resident becoming dehydrated.
The following is the sequence of events that lead to this resident demonstrating signs and symptoms of dehydration, resulting in the resident being transferred to hospital for the treatment of dehydration on.
-On an identified date staff documented in the clinical record that resident #001 did not have the ability to flex their neck the required amount to consume adequate amounts of fluid from a regular cup and requested a referral to restorative care staff.
Restorative care staff visited the resident on the same day and attempted to have the resident drink from an adaptive cup. Documentation in the clinical record indicated that the resident was not able to drink using this adaptive cup. Nursing staff documented that a straw had been used to assist the resident with drinking and that seemed to be working. The Registered Dietitian (RD) visited the resident on the same day and changed the resident's diet texture but did not assess the resident in relation to concerns of inadequate consumption of fluids. At this time the plan of care identified that the resident was a moderate nutritional risk related in part to chewing and swallowing difficulties and that the resident required total assistance with eating.
- Care identified in the care plan was not reviewed or revised when it was identified that the resident was at risk related to fluid consumption and staff continued to be directed to use an adaptive cup when assisting the resident to consume fluids. There were no directions in the resident's plan of care that a straw could be used to assist the resident consume fluids.
-There was no documentation in the clinical record that the RD assessed this resident's fluid requirements, hydration status or the risks identified related to poor

fluid consumption.
-On and identified date the resident's POA expressed concern for the health of the resident and a NP who was in the home at the time assessed the resident and noted that the resident had a dry tongue and decreased skin turgor. The NP ordered the resident to be sent to hospital for treatment of dehydration and sepsis from infected wounds.
- In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff in relation to the assessment of risk factors associated with dehydration that were being demonstrated by the resident and inaction in the review and revision of the plan of care for resident #001 when this resident's care needs changed resulted in the resident becoming dehydrated [redacted]. The resident was transferred to hospital for assessment and management of dehydration, a systemic infection and died in hospital. [s. 3. (1) 3.]

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Additional Required Actions:

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

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

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

Findings/Faits saillants :

1. The licensee did not ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system is complied with, in relation to the following: [8(1)b]
Staff in the home did not comply with the home's [Skin and Wound] policy, identified as #LTCE-1-3 and dated May 2012.
-The policy directed that all wounds will be reassessed weekly. Staff did not complete weekly wound assessments for resident #001, #002 and #003.
- The policy directed that registered staff were responsible to create and maintain a current resident care plan that reflects current status and location of a resident's wound or skin tears, risk factors present for skin breakdown, preventative measures to be taken to protect skin integrity, interventions undertaken to address alterations in skin integrity and promote healing and interventions related to pain management.
a)Resident #001's care plan did not contain the status and location of the resident's wounds, did not include immobility and peripheral vascular condition affecting wound healing or interventions undertaken to address alterations in skin integrity.
b)Resident #002's plan of care did not contain risk factors present for skin breakdown, preventative measures to be taken to protect the skin integrity or interventions undertaken to address alterations in skin integrity.
c)Resident #003's care plan did not contain risk factors present for skin breakdown. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance by ensuring staff in the home comply with the homes policies and procedures, including policies related to skin and wound care, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee did not ensure that the plan of care for resident #001 was based on, at a minimum, an interdisciplinary assessment of hydration status and any risks relating to hydration, in relation to the following:[26(3)14]
Resident #001 was assessed as having signs and symptoms of dehydration on an identified date and was transferred to hospital for treatment; however, the resident's plan of care was not based on an interdisciplinary assessment of hydration and any risks related to hydration. Nursing staff identified the resident as having difficulty drinking from regular glasses and cups on an identified date and requested restorative staff trial an adaptive cup due to the resident's limited neck mobility and inability of the resident to flex their neck to the degree required to drink from regular cups. Although restorative staff attempted to have the resident drink from the adaptive cup on the same day, documentation indicated the resident was not able to use the adaptive cup. Documentation also indicated and that nursing staff were using a straw to assist the resident to consume fluids which seemed to be working at that time. Clinical documentation did not include evidence that the resident was assessed by either nursing or dietary staff in relation to fluid requirements and care to be provided to ensure the resident consumed adequate fluids. The plan of care did not include risks associated with adequate hydration for this resident nor did care directions for staff include the use of a straw. [s. 26. (3) 14.]

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 and ensuring that the plan of care is based on, at a minimum, interdisciplinary assessments, including assessments related to hydration status and any risks relating to hydration, to be implemented voluntarily.

WN #7: 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 did not ensure that a written record was kept relating to each evaluation under the required skin and wound care program and the required pain management program that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the dates those changes were implemented, in relation to the following: [30(1)4]
a)At the time of this inspection the home provided a document indicating it was the 2012 annual evaluation of the skin and wound care program.
- The document did not contain the date of the evaluation.
- The document indicated that the Director of Care was the only person who participated in the evaluation.
- Data collected on the document was statistical in nature and did not include information about specific situations that had occurred over the year in relation to residents acquiring wounds while in the home, wound infection rates or situations where wounds did not heal according to care plan goals.
- Despite the document indicating that during a three month period in 2012 there were seven newly occurring staged wound and that six of those wounds were acquired in the home there was no indication of any changes made to the program. The action identified on the document was to continue with education and remind staff to pay close attention to pressure points. There were no specific changes or improvements to the program identified.
b)At the time of this inspection the home provided a document indicating it was the 2012 annual evaluation of the pain management program.
- The document indicates that the 2012 evaluation of this program was not completed. [s. 30. (1) 4.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that a written record is kept relating to each evaluation under the required programs, including the skin and wound program and the pain management program, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (1) The pain management program must, at a minimum, provide for the following:
1. Communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired. O. Reg. 79/10, s. 52 (1).

2. Strategies to manage pain, including non-pharmacologic interventions, equipment, supplies, devices and assistive aids. O. Reg. 79/10, s. 52 (1).
3. Comfort care measures. O. Reg. 79/10, s. 52 (1).
4. Monitoring of residents' responses to, and the effectiveness of, the pain management strategies. O. Reg. 79/10, s. 52 (1).

Findings/Faits saillants :

1. The pain management program did not provide communication and assessment methods for residents who were unable to communicate their pain or who were cognitively impaired in relation to the following: [52(1)1]
Staff confirmed that the pain assessment tool being used to assess resident #001, #002 and #003's pain was not appropriate for these residents because these residents were unable to communicate the location and intensity of the pain and these residents were also identified as having varying degrees of cognitive impairments. Registered staff interviewed also confirmed that they were unaware of any other assessment form being used in the home. The home's policy [Palliative Pain and Symptom Control] identified as # LTCE-CNS-E-4, dated May 2012 directs staff to use the Resident Assessment Instrument and if further assessment is required they are to use the [Ont. Comprehensive Pain Assessment Tool], both of which would require the resident to be able to communicate the location of pain and the intensity of pain. [s. 52. (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 and ensuring the pain management program provides communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee did not ensure that all staff who provided direct care to residents received, as a condition of continuing to have contact with residents, training in skin and wound care in accordance with O.Reg. 76/10 s. 221(1) 2, in relation to the following:
Information provided by the home at the time of this inspection including sign in sheets for training programs indicated that 48 of the 120 staff who provide direct care to residents did not receive training in the area of skin and wound care in 2012. [s. 76. (7) 6.]

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 and ensuring that all staff who provide direct care to the residents receive, as a condition of continuing to have contact with residents, training in skin and wound care on an annual basis, to be implemented voluntarily.

Issued on this 1st day of May, 2014

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PHYLLIS HILTZ-BONTJE (129)
Inspection No. / No de l'inspection :	2013_205129_0015
Log No. / Registre no:	H-000594-13
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 11, 2014
Licensee / Titulaire de permis :	REGENCY LTC OPERATING LP ON BEHALF OF REGENCY 100 Milverton Drive, Suite 700, MISSISSAUGA, ON, L5R-4H1
LTC Home / Foyer de SLD :	THE WATERFORD 2140 Baronwood Drive, OAKVILLE, ON, L6M-4V6
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	~~Paul Taylor~~ Carmensita Alcantara

To REGENCY LTC OPERATING LP ON BEHALF OF REGENCY, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

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 shall prepare, submit and implement a plan to ensure that care set out in the plan of care is provided to residents, including resident #002, #003 and #004 as specified in the plan of care. The plan is to include; but not limited to: a system to ensure staff providing direct care are aware of the specific risks to health and safety residents are experiencing as well as a process and schedule for monitoring direct care staff in the provision care to residents. The plan is to be submitted on or before March 20, 2014 to Phyllis Hiltz-Bontje, by mail, at 119 King Street, West, 11th Floor, Hamilton, Ontario L8P 4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

Grounds / Motifs :

1. Previously identified non-compliant as a CO on March 16, 2011, as a VPC on January 25, 2012 and as a VPC on September 23, 2013..
2. Three of three residents reviewed did not have care provided as specified in the plan of care related to skin and wound care, specifically staff did not comply with care directions related to assisting residents to turn and position.
a) Resident #002's plan of care directed staff to assist the resident to turn and reposition every two hours while in bed. This care was not provided as specified in the resident's plan of care when the resident was not assisted to turn and reposition for a period of time in excess of two hours on October 21, 2013
b) Resident #003's plan of care directed staff to turn and reposition the resident every two hours while in bed. This care was not provided as specified in the plan of care when the resident was not assisted to turn and reposition for a period of time in excess of two hours on October 22, 2013
c) Resident #004's plan of care directed staff to turn and reposition the resident every two hours. This care was not provided as specified in the plan of care when the resident was not assisted to turn and reposition for a period of time in excess of two hours on October 22, 2013. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 24, 2014

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee is to ensure that prompt action is taken when care being provided to residents in relation to wound healing, management of infections and hydration management had not been effective.

Grounds / Motifs :

1. Previously identified non-compliant as a VPC on June 2, 2011.
2. The licensee did not protect resident #001 from neglect by staff when this resident developed three pressure wounds and one wound that was not related to pressure while in the care of the home. Inaction by staff related to infection control, wound management and the management of risks related to hydration resulted in the resident being transferred to hospital for assessment and treatment of sepsis from wound infections and dehydration. This [redacted] pattern of inaction [redacted] jeopardized the well-being of the resident.
The licensee did not take action to protect this resident from neglect when:
- Staff and training records confirmed that all staff who provide direct care to residents did not receive annual training in the area skin and wound care in 2012.
- Staff confirmed that there was not a system in the home to monitor the care for residents who are dependent on staff for repositioning to ensure that these residents are assisted to turned and reposition at minimum every two hours.
- Staff confirmed that there was not a system or mechanism active in the home to ensure the interdisciplinary team met to review the care being provided to residents with wounds that were not healing, ongoing wound infections and resident's demonstrating risks related to adequate consumption of fluid in order that prompt action was taken and different approaches to care were initiated.
(129)

May 11, 2015
PHBarty

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2014

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. 50. (2) Every licensee of a long-term care home shall ensure that,
(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,
(i) within 24 hours of the resident's admission,
(ii) upon any return of the resident from hospital, and
(iii) upon any return of the resident from an absence of greater than 24 hours;
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;
(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee is to ensure that staff complete comprehensive weekly skin assessments for all residents exhibiting altered skin integrity, including resident #002 and #003.

Grounds / Motifs :

1. Previously identified non-compliant as a VPC on March 16, 2011 and as a CO on January 25, 2012.
2. Three of three residents reviewed who had wounds did not have weekly skin assessments completed.
3. Resident # 001 was identified as having four wounds. Staff and clinical documentation confirmed that these wounds were not assessed weekly.
- Wound #2 was assessed on May 10, 2013 and identified as having eschar in the wound base, assessed again 12 days later on May 23, 2013 when the wound was noted to be larger in size, contained eschar in the wound base and was noted to be draining a moderated amount of fluid. No further weekly wound assessment were completed until July 9, 2013 when the wound was identified as containing necrotic tissue, was red and warm to touch and had an odour.
- Wound #3 was assessed on May 10, 2013 and identified as having eschar in the wound base, assessed again 12 days later on May 23, 2013 where it was identified as being larger in size, moist and contained eschar in the wound base. No further weekly wound assessments were completed until July 9, 2013 when it was noted that there was an odour about the wound and the area around the wound was red and warm to the touch.
- Wound #4 was assessed on June 29, 2013, assessed again on July 5, 2013 indicating the wound had increased in length. The next weekly assessment was completed 14 days later and indicated the wound was healed.
- Wound #1 was assessed on June 7, 2013 and identified as having eschar in the wound base and the area around the wound was noted to be red and warm to the touch. The following assessment completed 10 days later indicated that there continued to be eschar in the base of the wound and the area around the wound continued to be red and warm to the touch. The following assessment completed 15 days later indicated the wound had increased in size, continued to contain eschar in the wound base, was red and warm to touch and there was an odour about the wound.
4. Clinical documentation indicated resident #002 had two wounds, but did not have weekly skin and wound assessments completed. Staff and clinical documentation confirmed that there were two weekly skin assessments completed on August 16 and 28, 2013, there were four skin assessments documented in September 2013 that were not completed within seven day periods of each other and there were two assessments completed on October 8 and 22, 2013
5. At the time of this inspection resident #003's plan of care indicated that the

resident had one wound, but did not have weekly skin assessments completed. Staff and clinical records confirmed that the last skin assessment completed was on September 15, 2013 , 24 days prior to the initiation of this inspection. (129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 24, 2014

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Ontario

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

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

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.
12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.
22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.
23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that residents who demonstrate poor wound healing, infections and poor fluid consumption are regularly assessed by the interdisciplinary team and that care is provided based on those needs.
The plan is to include, but not limited to:
-The development of a communication system to alert members of the interdisciplinary team when the above noted conditions are being demonstrated by residents;
-A process for monitoring residents who demonstrate the above noted conditions;
-A process to ensure that the members of the interdisciplinary team collaborate with each other in the assessment and reassessment of residents demonstrating the above noted conditions;
-A process for the regular review of the care being provided to residents demonstrating the above noted conditions to determine if care being provided is effective;
-A mechanism to ensure that all staff providing direct care to residents receive training in skin and wound care, at minimum, annually.
The plan is to be submitted on or before March 20, 2014 to Phyllis Hiltz-Bontje, by mail at 119 King Street, West, 11th Floor, Hamilton, Ontario L8P4Y7 or by e-mail at Phyllis.Hiltzbontje@Ontario.ca.

- A process form monitor

Grounds / Motifs :

1. Previously identified non-compliant as a VPC on April 11, 2012.
2. Inaction by staff related to wound assessment, evaluation of the effectiveness of care being provided, revising the plan of care when it was identified that care being provided to the resident was not effective, ensuring directions for care were accurate and complete as well as monitoring of care being provided to resident #001 resulted in this resident experiencing ongoing wound infections and poor wound healing.

a) Clinical documentation indicated wound #1 was reported by staff working nights on an identified date, and was described as an abrasion. Documentation indicated the wound was cleansed and a dressing was applied. The following identifies the sequence of events, related to this wound, over a two month period of time when the resident was transferred to hospital for the treatment of sepsis from infected wounds:

-Staff working the day shift on May 30, 2013 identified this wound had increased in size. Staff did not complete an assessment of this wound and did not identify the possible cause of this injury in order to reduce the risk of further injury to the resident. There was no evidence in the clinical record that a treatment plan had been developed in related to the management of this wound. Staff interviewed at the time of this inspection indicated that in the past wounds in the home were assessed and managed by an Enteralstomal Nurse (ET) who visited the home through a contract with the Community Care Access Centre; however this service was no longer available and staff lacked the confidence and experience to assess and manage wounds.

-Five days after the initial report of this injury staff completed a weekly skin and wound assessment for this wound and indicated there was eschar in the wound base and the skin area around the wound was red and warm to the touch. Documentation on this assessment form indicated that staff did not take a swab of the area, despite signs of a possible infection. On this same day the physician ordered a dressing containing iodosorb was to be applied and this dressing was to be changed three times a week. The physician order the resident to receive oral antibiotics based on the signs of a possible wound infection.

-Four days later, staff completed a weekly skin and wound assessment. This assessment indicated there had been no change in the wound. There was no documentation in the clinical record to indicate that staff took any action when it appeared the treatment plan was not effective in cleaning the wound base or addressing the signs and symptoms of infection.

-Three days later, the physician documented in the clinical record indicating the antibiotic being given to the resident was to be changed and the resident was to receive this antibiotic for a two week period. The physician also requested a referral to a wound specialist, that the resident be placed on a specialized mattress designed to reduce pressure on the resident's skin and ordered a specialized examination to confirm a suspicion that reduced blood flow was contributing to poor wound healing. A Personal Support Worker (PSW) interviewed at the time of this inspection confirmed that the resident's legs would have remained in a dependent position for long periods of time during the day. Staff identified the resident's daily routine consisted of being assisted into the wheelchair for breakfast, usually remaining in the wheelchair until after lunch, being assisted into bed in the early afternoon, assisted into the wheelchair in the late afternoon for the dinner meal and then remaining in the wheelchair for three or four hours after dinner while visiting with family. Registered staff and clinical documentation confirmed that no care directions were provided to direct care staff in relation to positioning the resident to maximize blood flow and no actions were taken to improve wound healing by ensuring that the affected area was positioned in a way that would maximize the flow of blood, despite the resident's physician indicating this could be a factor in poor wound healing. There was no documentation in the clinical record that a discussion took place regarding the need to change the type of dressing being applied based on staff's documentation that there had been no change in the condition of this wound.
- The following day a Nurse Practitioner (NP) visited the resident in response to the physician's order that a wound specialist assess the resident. There was no documentation in the clinical record of the appearance of the wound as a result of this assessment. The NP documented that decreased pulses where noted confirming that there were barriers to blood supply in the affected area and ordered that the resident be repositioned every hour in order to reduce pressure on the resident's skin and improve wound healing. Staff and clinical documentation confirmed that care directions for the resident were not changed based on directions from the NP that the resident be repositioned every hour and directions in the documents that the home used to describe the care to be provided to the resident indicated that resident was to be repositioned every two to three hours. Registered staff indicated that they were unable to verify that the resident was being repositioned hourly and confirmed that they did not monitor the care being provided by the direct care staff, despite indications that this resident's wound was not healing.
-Two days later a second NP assessed the resident and ordered that the wound was to be painted with betadine, a non-adherent dressing be applied and

increased the frequency of dressing changes to daily. Staff did not complete a weekly skin and wound assessment scheduled for June 14, 2013. There was no documentation in the clinical record indicating the status of the wound or if the current treatment plan was effective in moving towards the goal of care identified in the resident's care plan that the wound would heal and no indication if the antibiotic medication ordered on was effective in managing the wound infection.
-Seven days later two NP's visited the resident and attempted to perform the specialized diagnostic procedure the physician had ordered on June 10, 2013 to determine if diminished blood flow was contributing to poor wound healing. Clinical documentation indicated that the procedure was not completed due to resistance on the part of the resident.
-Four days later staff completed a weekly skin and wound assessment and indicated the condition of the wound had not changed. Documentation on this assessment form indicated the wound base contained eschar and the area around the wound remained red and warm to touch. The resident's course of treatment with antibiotics was about to finish and there was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan when staff continued to document that the condition of the wound had not changed.
-The following day the physician documented in the clinical record that this wound was deteriorating; however, there were no changes to the treatment plan either in relation to dressing the wound or infection control management. Care directions for staff identified in the care plan were not altered and those directions remain the same as were originally identified on June 8, 2013
-Four days later staff documented in the clinical record that the wound was deteriorating; however, the specific appearance of the wound was not documented. Staff also indicated that the physician would assess the wound in 10 days. No action was taken to address the deteriorating condition of this wound.
-Staff did not complete a scheduled weekly skin and wound assessment on June 30, 2013.
-Eight days after staff continued to document that this wound was deteriorating; the NP assessed the wound and noted a small amount of wound drainage and an area of eschar in the centre of the wound. A swab of the wound drainage was obtained and the wound was identified as stage 4 wound. Later the same day staff documented that the dressing was changed and indicated the ongoing presence of infection in the wound when it was documented that the wound was now producing purulent drainage. Staff also documented that the wound swab taken by the NP earlier in the day was destroyed because the laboratory

indicated the swab would not remain viable over the weekend. The clinical record indicated there were no changes made in the treatment plan for this wound at this time.
-The following day staff documented that the dressing was changed and there was now a moderate amount of purulent drainage as well as a foul odour was noted from the wound. Clinical documentation indicated there were no changes made to the treatment plan for this wound at this time.
-The following day staff indicated the resident's condition had deteriorated and the resident now had an increased temperature, for which the resident was given medication designed to reduce temperature. Staff also indicated a wound swab was taken. On this same day the physician documented a note indicating the wound was not doing well with no signs of healing and ordered the resident to begin treatment with another antibiotic for a two week period and the wound dressing was to remain the same as was originally ordered 26 days previously.
- The following day staff completed a weekly skin and wound assessment and indicated the wound continued to deteriorate when they documented that the wound was now double the length, slightly wider, was moist, eschar was noted in the base, there was a foul odour about the wound and the area around the wound remained warm to the touch. A diagnostic procedure of the affected area was completed.
-Two days later, the physician indicated a discussion was held with the resident's Power of Attorney (POA) with respect to the results of the diagnostic procedure. The results indicated a significant blockage of the flow of blood in the affected area. There were no changes to the plan of care related to positioning the resident in order to maximize blood flow and the resident continued to sit in a wheelchair for long periods of time during the day.
-The following day staff completed a weekly skin and wound assessment, another weekly skin and wound assessment seven days later and a third weekly skin assessment seven days later. Documentation on all of these assessments indicated that the wound continued to be moist, contained eschar in the wound base, had a foul odour and the area around the wound was red and warm to touch. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience wound infection and poor wound healing.
-Staff did not complete a weekly skin and wound assessment that was scheduled on August 2, 2013. Two days later staff completed a weekly skin a wound assessment that indicated the resident's wound continued to deteriorate when they documented that the wound now contained a moderate amount of

bloody discharge. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience wound infection and poor wound healing.
-Four days later, the resident's POA expressed concern about the resident's condition and requested the resident be placed on antibiotics to combat infection. Staff approached a NP who was seeing other residents in the home and requested the resident be assessed. The NP assessed the resident as possibly having a systemic infection related to ongoing wound infection, identified the resident as being dehydrated and ordered the resident to be transferred to hospital for assessment and treatment.
-Documentation provided by the home at the time of this inspection indicated that not all staff who provide direct care to residents had received training in relation to skin and wound care.
-Staff did not follow directions contained in the home's skin and wound policy when providing care to resident #001.
-Staff did not complete weekly wound assessments.
-Staff in the home did not ensure that resident #001's plan of care included information to PSWs providing basic care when there were not directions for positioning the resident, there were inaccurate directions for the turning and positioning schedule for this resident and there was no information with respect to wound infections and directions for staff related to hygiene/bathing needs.
-Registered staff confirmed that care being provided to the resident by PSWs was not monitored in order to ensure the care identified related to turning and positioning the resident was provided.
-In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff in relation to the management of this wound jeopardized resident #001's health and well-being. This inaction contributed to poor wound healing and ongoing wound [redacted]. The resident was transferred to hospital for assessment and management of sepsis and poor wound healing and died in hospital.

May 11, 2015
PHBrdge

b) Wound #2 was identified when staff completed a weekly skin and wound assessment for this wound and indicated the wound was 0.8cm. x 1.0cm, the wound was dry and there was eschar in the base of the wound. There was no evidence in the clinical record related to the plan of care for the management of this wound. The following identifies the sequence of events, related to this wound, over a three month period of time up until the resident was transferred to hospital for the treatment of sepsis from infected wounds:

-Thirteen days after staff identified this wound the NP ordered staff to continue to cover the area with foam dressing to help with drainage and staff were to monitor for any additional similar wounds. Documentation by the NP indicated that since the last assessment 13 days ago this wound had deteriorated and now there was drainage from the wound that required a dressing that was designed to manage drainage. On this same day staff completed a weekly skin and wound assessment and indicated that the wound had increased in size, that the wound was moist and there was eschar in the wound base. Although the NP saw the resident on this day there were no changes to the treatment plan for this wound, despite the wound increase in size and the change in character of the wound.
- Staff did not complete a weekly skin and wound assessment on May 30, 2013 and there was no current information in the clinical record with respect to the condition and appearance of this wound.
- On June 3, 2013 staff documented that this wound dressing was changed following a shower; however there was no indication that an assessment of the wound was completed and there was no documentation related to the appearance and condition of the wound. On this same date the physician ordered the resident to receive antibiotics; however there is no indication that the physician assessed this wound.
- Staff did not complete a weekly skin and wound assessment on June 6, 2013.
- On June 7, 2013 staff documented that the dressing over this wound was changed; however there is no evidence that an assessment was completed. The last documentation related to the condition and appearance of this wound was entered into the clinical record 16 days previously.
- Three days later, the physician documented in the clinical record indicating the antibiotic being given to the resident was to be changed and the resident was to receive this antibiotic for a two week period. The physician also requested a referral to a wound specialist, that the resident be placed on a specialized mattress designed to reduce pressure on the resident's skin and ordered a specialized examination to confirm a suspicion that reduced blood flow was contributing to poor wound healing. A Personal Support Worker (PSW) interviewed at the time of this inspection confirmed that the affected area would have remained in a dependent position for long periods of time during the day. Staff identified the resident's daily routine consisted of being assisted into the wheelchair for breakfast, usually remaining in the wheelchair until after lunch, being assisted into bed in the early afternoon, assisted into the wheelchair in the late afternoon for the dinner meal and then remaining in the wheelchair for three or four hours after dinner while visiting with family. Registered staff and clinical

documentation confirmed that no care directions were provided to direct care staff in relation to positioning the resident to maximize blood flow and no actions were taken to improve wound healing by ensuring the affected area was positioned in a way that would maximize the flow of blood, despite the resident's physician indicating this could be a factor in poor wound healing. There was no documentation in the clinical record that a discussion took place regarding the need to change the type of dressing being applied based on staff's documentation that there had been no change in the condition of this wound. Clinical documentation indicated that there was no current information about the condition or appearance of this wound since it was last documented 19 days ago and there had been no changes made to the treatment plan for this wound.
- A day after the physician documented in the clinical record a Nurse Practitioner (NP) visited the resident in response to the physician's order that a wound specialist assess the resident. There was no documentation in the clinical record of the appearance of the wound as a result of this assessment. The NP documented that decreased pulses where noted in the affected area confirming that there were barriers to blood supply to the affected area and ordered that the resident be repositioned every hour in order to reduce pressure on the resident's skin and improve wound healing. Staff and clinical documentation confirmed that care directions for the resident were not changed based on directions from the NP that the resident be repositioned every hour and directions in the documents that the home used to describe the care to be provided to the resident indicated that resident was to be repositioned every two to three hours. Registered staff indicated that they were unable to verify that the resident was being repositioned hourly and confirmed that they did not monitor the care being provided by the direct care staff, despite indications that this resident's wound was not healing.
- The following day the NP noted in the clinical record that wound #2 measured 3.5cm x 2cm, there was black eschar in the wound base, identified this wound as a stage II wound, identified that pedal pulses are decreased and there was pitting edema in the area. The NP ordered a change in the wound treatment and the wound was be painted with betadine, a non-adherent dressing be applied, the resident was be repositioned every hour and requested a referral to the Occupational Therapist (OT) related to off-loading of pressure to the affected area.
- The following day the OT documented that it was recommended that the resident have a pillow between the thighs when in bed and between feet to minimize rubbing.
- Staff did not complete a weekly skin and wound assessment on June 13, 2013.
- Five days after the NP saw the resident staff documented in the progress notes

that the wound seems to be improving, but do not document the condition or appearance of the wound.
- Staff did not complete a weekly skin and wound assessment on June 20 or 27, 2013
- There was no evidence in the clinical record that staff assessed the effectiveness of the antibiotic treatment ordered seventeen days prior, in reducing the signs of a possible infection in this wound.
- The NP visited the resident 24 days after the last visit and ordered that staff were to continue with the current dressing orders, but did not specify which wounds this direction applied to. There was no current information about the condition and appearance of this wound since the last documentation 24 days ago.
- Two days later staff indicated the resident's condition has deteriorated and the resident now had an increased temperature, for which the resident was given medication designed to reduce temperature. Staff also indicated a swab was taken from wound #1. On the same day the physician ordered the resident to begin treatment with another antibiotic for a two week period; however did not indicate wound #2 was assessed.
- The following day staff completed a weekly skin and wound assessment and indicated the wound was identified as a stage II wound, was moist, there was an door about the wound and the area around the wound was red and warm to the touch.
- Three days later staff completed a weekly skin and wound assessment indicating there was a slight increase in the size of the wound and the wound continued to be moist, odour was present and the skin around the wound remained red and warm to touch. There was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan when staff identified the presence of ongoing infection and poor wound healing.
-Seven days later staff completed a weekly skin and wound assessment and indicated the size of the wound had not changed, the wound continued to be moist, necrotic tissue was noted in the base, there continued to be an odour about the wound and the skin around the wound remained warm to touch. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered, despite the resident continuing to experience a wound infection and a deteriorating condition of this wound.
- There was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan following a

course of antibiotics ordered 11 days ago. Staff continued to document signs and symptoms of a wound infection when it was documentation indicated there was an odour about the wound and the area around the wound was red and warm to touch.
- Three days after the last skin assessment the physician ordered that staff were to continue to paint the wound with betadine, but did not make a note about the condition or appearance of this wound.
- Staff completed a weekly skin and wound assessment four days later indicating there had been a slight increase in the size of the wound, the wound remained moist, there was an odour about the wound and the area around the wound was red and warm to touch. The clinical record confirmed that there were no changes made to the plan of care for this wound
- Sixteen days after the last assessment staff complete a weekly skin and wound assessment indicating there had been no change in the wound and the wound continued to have an odour, the skin around the wound remains red and warm to touch. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience wound infection and poor wound healing.
- Four days later the resident's POA expressed concern about the resident's condition and requested the resident be placed on antibiotics to combat infection. Staff approached a NP who was seeing other residents in the home and requested the resident be assessed. The NP assessed the resident as possibly having a systemic infection related to ongoing wound infection, identified the resident as being dehydrated and ordered the resident to be transferred to hospital for assessment and treatment.
- Documentation provided by the home at the time of this inspection indicated that not all staff that provide direct care to residents had received training in relation to skin and wound care.
- Staff did not follow directions contained in the home's skin and wound policy when providing care to resident #001.
- Staff did not complete weekly wound assessments.
- Staff in the home did not ensure that resident #001's plan of care included information to PSWs providing basic care when there were not directions for positioning the resident, there were inaccurate directions for the turning and positioning schedule for this resident and there was no information with respect to wound infections and directions for staff related to hygiene/bathing needs.
- Registered staff confirmed that care being provided to the resident by PSWs was not monitored in order to ensure the care identified related to turning and

positioning the resident was provided.
- In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff in relation to the management of this wound jeopardized resident #001's health and well-being. This inaction contributed to poor wound healing and ongoing wound infection [redacted]. The resident was transferred to hospital for assessment and management of sepsis and poor wound healing and died in hospital.

May 11, 2015
PHBudge

c) Wound #3, a second wound located in the same area as wound #3 was identified when staff completed a weekly skin and wound assessment and indicated the wound was 0.4cm. x 0.5.cm, the wound was dry and there was eschar in the base of the wound. There was no evidence in the clinical record related to the plan of care for the management of this wound. The following identifies the sequence of events, related to this wound, over a three month period of time up until the resident was transferred to hospital for the treatment of sepsis from infected wounds:
- Staff did not complete a weekly skin and wound assessment of this wound on May 17, 2013.
- Thirteen days after the identification of this wound the NP ordered staff to continue to cover the wound with a foam dressing to help with drainage and staff were to monitor for any similar wounds. Documentation by the NP indicated that since the last assessment 13 days ago this wound had deteriorated and now there was drainage from the wound that required a specialized dressing designed to manage drainage. On this same day staff completed a weekly skin and wound assessment and indicated that the wound had increased in size, that the wound was moist and there was eschar in the wound base. Although the NP saw the resident on this day there were no changes to the treatment plan for this wound, despite the increase in size of wound and the change in character of the wound.
- Staff did not complete a weekly skin and wound assessment on May 30, 2013 and there was no information in the clinical record of the condition or appearance of this wound since the last assessment completed seven days prior.
- Eleven days after the previous assessment staff documented that this dressing was changed following a shower; however there is no indication that an assessment of the wound was completed and there has been no documentation related to the appearance and condition of the wound. On this same date the physician ordered the resident to receive antibiotics; however there was no indication that the physician assessed this wound.

- Staff did not complete a weekly skin and wound assessment on June 6, 2013.
- Four days after the last documentation that the dressing over this wound was changed staff again documented that the dressing over this wound was changed; however there was no evidence that an assessment was completed. There was no current information regarding the appearance and condition of this wound since it was last documented 16 days ago.
- Three days later the physician documented in the clinical record indicating the antibiotic being given to the resident was to be changed and the resident was to receive this antibiotic for a two week period. The physician also requested a referral to a wound specialist, that the resident be placed on a specialized mattress designed to reduce pressure on the resident's skin and ordered a specialized examination to confirm a suspicion that reduced blood flow was contributing to poor wound healing. A Personal Support Worker (PSW) interviewed at the time of this inspection confirmed that the affected area would have remained in a dependent position for long periods of time during the day. Staff identified the resident's daily routine consisted of being assisted into the wheelchair for breakfast, usually remaining in the wheelchair until after lunch, being assisted into bed in the early afternoon, assisted into the wheelchair in the late afternoon for the dinner meal and then remaining in the wheelchair for three or four hours after dinner while visiting with family. Registered staff and clinical documentation confirmed that no care directions were provided to direct care staff in relation to positioning the resident to maximize blood flow and no actions were taken to improve wound healing by ensuring the resident was positioned in a way that would maximize the flow of blood, despite the resident's physician indicating this could be a factor in poor wound healing. There was no documentation in the clinical record that a discussion took place regarding the need to change the type of dressing being applied based on staff's documentation that there had been no change in the condition of this wound. There was no evidence that this wound was assessed, there was no documentation in the clinical record describing the wound and there had been no changes made to the treatment plan for this wound.
- The following day a Nurse Practitioner (NP) visited the resident in response to the physician's order that a wound specialist assess the resident. There was no documentation in the clinical record of the appearance of the wound as a result of this assessment. The NP documented that decreased pulses where noted in the affected area, confirming that there were barriers to blood supply and ordered that the resident be repositioned every hour in order to reduce pressure on the resident's skin and improve wound healing. Staff and clinical documentation confirmed that care directions for the resident were not changed

based on directions from the NP that the resident be repositioned every hour and directions in the documents that the home used to describe the care to be provided to the resident indicated that resident was to be repositioned every two to three hours. Registered staff indicated that they were unable to verify that the resident was being repositioned hourly and confirmed that they did not monitor the care being provided by the direct care staff, despite indications that this resident's wound was not healing.
- The following day the NP noted in the clinical record that wound #2 measured 7.0cm x 4.0cm, identified this wound as a stage II wound, identified that pedal pulses were decreased and there was pitting edema in the area. The NP ordered a change in the wound treatment and the wound was to be painted with betadine, a non- adherent dressing be applied, the resident was to be repositioned every hour and requested a referral to the Occupational Therapist (OT) related to off-loading pressure to the affected area.
- The following day the OT documented that it was recommended that the resident have a pillow between the thighs when in bed and between feet to minimize rubbing.
- Staff did not complete a weekly skin and wound assessment on June 13, 2013.
- Five days after the NP's assessment staff note in the progress notes that this wound seems to be improving, but did not document the condition or appearance of the wound.
- Staff did not complete a weekly skin and wound assessment on June 20 or 27, 2013
- There was no evidence in the clinical record that staff assessed the effectiveness of the antibiotic treatment ordered on June 10, 2013.
- Nineteen days after the last wound assessment was completed the NP ordered that staff were to continue with the current dressing orders, but did not specify which wounds this direction applied to. There was no indication in the clinical record that this wound was assessed at this time and there was no current information about the condition or appearance of this wound since it was last document 24 days ago.
- Two days later staff indicated the resident's condition has deteriorated and the resident now had an increased temperature, for which the resident was given medication designed to reduce temperature. Staff also indicated a wound swab was taken from wound #1. On the same day the physician ordered the resident to begin treatment with another antibiotic for a two week period; however did not indicate wound #2 was assessed and there is no indication of the condition or appearance of this wound in the clinical record.
- The following day staff completed a weekly skin and wound assessment and

indicated the wound was 2.0cm x 1.6cm, identified as a stage II wound, the wound was noted to be moist, there was necrotic issue noted, there was an odour about the wound and the area around the wound was red and warm to the touch. There was no documentation in the clinical record to indicate that staff took any action when necrotic tissue was noted in the wound
- Three days later staff completed a weekly skin and wound assessment indicating there was an increase in the size of the wound and the wound continued to be moist, necrotic tissue was noted in the wound, odour was present and the skin around the wound remained red and warm to touch. There was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan when staff identified an increase in the size of the wound, the presence of necrotic tissue, the presence of ongoing infection and poor wound healing.
-Seven days later staff completed a weekly skin and wound assessment and indicated the size of the wound had increased and was now 4.5cm x 2.5, the wound continued to be moist, necrotic tissue was noted in the base, there continued to be an odour about the wound and the skin around the wound remained warm to touch. There was no evidence in the clinical record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience a wound infection and a deteriorating condition of this wound.
- There was no indication in the clinical record that staff made an effort to contact the physician or initiate any change in the treatment plan when the resident's course of antibiotics ordered on July 8, 2013 finished and staff continued to document that there was an odour about the wound and the skin around the wound was red and warm to touch.
- Three days later the physician ordered that staff were to continue to paint the wound with betadine; however, there was no documentation about the condition or appearance of this wound.
- Four days later staff completed a weekly skin and wound assessment indicating there had been no improvement in the condition and appearance of this wound. The clinical record indicated that staff took no action when it appeared the treatment plan was not effective in achieving the goal identified in the plan of care to heal this wound.
-Nine days later staff complete a weekly skin and wound assessment indicating the wound had increased in size to 8.0cm x 4.0c, the wound continued to be moist, contain necrotic tissue, continued to have an odour and the skin around the wound remained red and warm to touch. There is no evidence in the clinical

record, including physician orders, progress notes or the care plan that indicated the treatment plan for the resident was altered throughout this period of time, despite the resident continuing to experience wound infection and poor wound healing.
- Four days later the resident's POA expressed concern about the resident's condition and requested the resident be placed on antibiotics to combat infection. Staff approached a NP who was seeing other residents in the home and requested the resident be assessed. The NP assessed the resident as possibly having a systemic infection related to ongoing wound infection, identified the resident as being dehydrated and ordered the resident to be transferred to hospital for assessment and treatment.
- Documentation provided by the home at the time of this inspection indicated that not all staff who provided direct care to residents had received training in relation to skin and wound care.
- Staff did not follow directions contained in the home's skin and wound policy when providing care to resident #001.
- Staff did not complete weekly wound assessments.
- Staff in the home did not ensure that resident #001's plan of care included information to PSWs providing basic care when there were not directions for positioning the resident, there were inaccurate directions for the turning and positioning schedule for this resident and there was no information with respect to wound infections and directions for staff related to hygiene/bathing needs.
- Registered staff confirmed that care being provided to the resident by PSWs was not monitored in order to ensure the care identified related to turning and positioning the resident was provided.
- In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff in relation to the management of this wound jeopardized resident #001's health and well-being. This inaction contributed to poor wound healing and ongoing wound infection [redacted]. The resident was transferred to hospital for assessment and management of sepsis and poor wound healing and died in hospital on August 24, 2013.

May 11, 2015
PHBrady

2.Inaction by staff in the assessment of risk factors associated with dehydration that were being demonstrated by the resident and in the review and revision of the plan of care for resident #001 when this resident's care needs changed resulted in the resident becoming dehydrated.
The following is the sequence of events that lead to this resident demonstrating signs and symptoms of dehydration, resulting in the resident being transferred to hospital for the treatment of dehydration on.

-On an identified date staff documented in the clinical record that resident #001 did not have the ability to flex their neck the required amount to consume adequate amounts of fluid from a regular cup and requested a referral to restorative care staff. Restorative care staff visited the resident on the same day and attempted to have the resident drink from an adaptive cup. Documentation in the clinical record indicated that the resident was not able to drink using this adaptive cup. Nursing staff documented that a straw had been used to assist the resident with drinking and that seemed to be working. The Registered Dietitian (RD) visited the resident on the same day and changed the resident's diet texture but did not assess the resident in relation to concerns of inadequate consumption of fluids. At this time the plan of care identified that the resident was a moderate nutritional risk related in part to chewing and swallowing difficulties and that the resident required total assistance with eating.
- Care identified in the care plan was not reviewed or revised when it was identified that the resident was at risk related to fluid consumption and staff continued to be directed to use an adaptive cup when assisting the resident to consume fluids. There were no directions in the resident's plan of care that a straw could be used to assist the resident consume fluids.
-There was no documentation in the clinical record that the RD assessed this resident's fluid requirements, hydration status or the risks identified related to poor fluid consumption.
-On and identified date the resident's POA expressed concern for the health of the resident and a NP who was in the home at the time assessed the resident and noted that the resident had a dry tongue and decreased skin turgor. The NP ordered the resident to be sent to hospital for treatment of dehydration and sepsis from infected wounds.
- In accordance with the definition of neglect identified in O. Reg. s. 5, inaction by staff in relation to the assessment of risk factors associated with dehydration that were being demonstrated by the resident and inaction in the review and revision of the plan of care for resident #001 when this resident's care needs changed resulted in the resident becoming dehydrated. [redacted] The resident was transferred to hospital for assessment and management of dehydration, a systemic infection and died in hospital. [s. 3. (1) 3.]

May 11, 2015
[illegible signature]

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 15, 2014

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 or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance 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 and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

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

Health Services Appeal and Review Board and the Director

Attention Registrar 151 Bloor Street West 9th Floor Toronto, ON M5S 2T5	Director c/o Appeals Coordinator Performance Improvement and Compliance 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire Commission d'appel et de révision des services de santé 151, rue Bloor Ouest, 9e étage Toronto (Ontario) M5S 2T5	Directeur a/s Coordinateur des appels Direction de l'amélioration de la performance et de la conformité Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Ontario, ON M5S-2B1 Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 11th day of February, 2014 (A1) May 11, 2015

Signature of Inspector / Signature de l'inspecteur : PHBontje

Name of Inspector / Nom de l'inspecteur : PHYLLIS HILTZ-BONTJE

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