Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 9, 2020	2020_833763_0014	005954-20, 006166-20, 009703-20, 014450-20	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

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

The Village of Humber Heights
2245 Lawrence Avenue West ETOBICOKE ON M9P 3W3

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

IANA MOLOGUINA (763), JULIEANN HING (649)

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): August 12, 13, 14, 17, 18, 19, 20, 24, 25, 26 and 27, 2020.

The following intakes were completed during this complaint inspection:

- Log #005954-20 was related to bathing, wound care and neglect.
- Log #006166-20 was related to wound care and neglect.

During the course of the inspection, the inspector(s) spoke with the Assistant General Manager (AGM), Director of Nursing Care (DNC), Assistant Director of Nursing Care (ADNC), Registered Dietitian (RD), Registered Nurse (RN), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), families and residents.

During the course of this inspection, the inspector reviewed resident clinical records and conducted observations, including staff-resident interactions and resident care provision.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Skin and Wound Care

During the course of this inspection, Non-Compliances were issued.
- **5 WN(s)**
- **4 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 48. Required programs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the skin and wound care program that promoted skin integrity; prevented the development of wounds and pressure ulcers; and provided effective skin and wound care interventions, was implemented in the home.

Resident #014's clinical records were reviewed due to complaints lodged with the Ministry of Long-Term Care (MLTC) regarding frequent falls, wound care, repositioning, bathing, hygiene care concerns, and neglect. The resident exhibited periods of altered skin integrity related to their falls history, age, and diagnosis. On a specified date, staff first noted a skin injury on the resident’s scheduled weekly skin observation tool in Point Click Care (PCC) and a dressing order was implemented on the Treatment Administration Record (TAR). There were no referrals completed to the skin care lead or the registered dietitian (RD) for this wound. The wound continued to be noted on the scheduled weekly skin observation tools for the next five to six months until the resident passed away. The observation tools indicated the location of the injury and that dressing and antibiotic orders were in place, but no description of its status.

A quarterly head to toe assessment was completed in PCC three months after the wound was first noted, indicating the resident had impaired skin integrity, but no description of the status of the skin impairment, and no weekly skin observation tool completed.

The first referral for the injury was submitted to the skin care lead three months after the wound was first discovered, when it was noted that the injury had deteriorated. The skin

care lead called the resident's Substitute Decision Maker (SDM) to request consent for the Enterostomal Therapy (ET) nurse to assess the wound; the SDM declined since the resident was already scheduled for another appointment.

Staff submitted a referral to the skin care lead for a new wound approximately one week after. A dressing order was scheduled on the TAR. This referral was addressed by the skin care lead 13 days after the referral was originally submitted, and the skin care lead provided several recommendations, including encouraging the staff to initiate a weekly skin observation tool that assessed all current skin impairments. There was no referral to the RD noted. The resident was then admitted to hospital and staff completed a head to toe assessment in PCC upon the resident's return from the hospital. They indicated the resident had impaired skin integrity but did not initiate a skin observation tool to describe the type of impairment. There was no documentation completed on the status of the resident's new wound on their return from the hospital. The staff referred to the RD for the resident's return from hospital and the RD assessed the resident but did not assess their skin status. Another weekly skin observation tool was completed following the resident's hospital admission, which noted the size of the first wound and that there was no sign of infection; there was no note on the status of the second wound.

Resident #014 was admitted to the hospital once again for an emergency invasive surgical procedure; the resident came back to the home with a specified permanent impairment as a result of the first wound. Staff completed a head to toe assessment in PCC upon readmission to the home, indicating that resident #014 had impaired skin integrity. Staff did not complete a weekly skin observation tool to describe the type of impairment, such as the specified permanent impairment. There were also no dressing orders started on the TAR for the impaired site. However, the RD assessed the resident's skin post hospitalization, noting the presence of the impaired site and the second wound that was originally mentioned by the staff on their referral to the skin care lead.

A few weeks later, staff completed a weekly skin observation tool indicating the second wound had grown significantly in size. There was no comment noted of the specified permanent impairment, but a referral was sent to the dietitian and the skin care lead for the worsened wound. Resident Assessment Instrument (RAI) staff #151 followed up on the skin care lead referral and provided several recommendations, including encouraging the staff to initiate a weekly skin observation tool that assessed all current skin impairments on the tool. No ET nurse involvement was considered at this time.

The RD was referred again a few days after due to the resident's declining intake and

wound deterioration. The dietitian assessed the resident's skin status, weight and intake at the time, and increased the resident's supplement (which was started a few days earlier due to a referral for declined intake). The RD also changed the resident to high nutrition risk. A few days later, the resident passed away.

A) Staff and others involved in the different aspects of care failed to collaborate with each other in the assessment of resident #014 so that their assessments were integrated, consistent with and complemented each other.

RPN #104 reported that they were involved in resident #014's wound care, including completing several of the resident's scheduled weekly skin observation tools when the resident had the first injury. RPN #104 indicated staff were expected to describe the status of the wound (i.e. improved, worsened or healed) under the comments section of the tool so that all staff could appropriately monitor the resident's skin status. RPN #104 left that section blank when completing the weekly observation tools for resident #014 and did not remember why. RPN #104 also indicated that staff were expected to refer to the dietitian and skin care lead for altered skin integrity, and that they should have been referred for this injury when it was first discovered.

RPN #113 confirmed they discovered the second wound. RPN #113 also referred to the skin care lead and started a new order on the TAR. RPN #113 did not know why the second wound was not reviewed on any following weekly skin assessments, or head to toe assessments, until the end of that month when staff discovered the wound was much larger. RPN #113 also indicated that they were expected to refer to the dietitian for this wound when it was first discovered but failed to do so. RPN #113 believed staff would be monitoring the wound in addition to the first wound on the already scheduled weekly skin observation tools, so they did not initiate another weekly skin observation tool. RPN #113 did not work with the resident again until the following month when the resident had already declined, and the larger wound was discovered.

RPN #120 confirmed they completed the head to toe assessment for resident #014 when the resident came back from their first hospital visit. RPN #120 confirmed that staff were expected to assess the resident's skin post hospitalization and indicate if the resident had any impairment in skin integrity on the head to toe assessment form in PCC. If so, the staff were expected to initiate a new weekly skin observation tool at the same time as completing the head to toe assessment. This would allow all staff to appropriately monitor the resident's skin status. RPN #120 confirmed that they did not initiate a new

weekly skin tool because they thought the head to toe assessment was the only form requiring completion; it was the only form that was initiated by the RAI department for nursing staff to complete. After speaking with inspector #763, RPN #120 acknowledged it was their responsibility to initiate a weekly skin observation tool. From what they were able to recall, they were not aware of the second wound already discovered and believed the skin impairment that was noted on their head to toe assessment was the resident's first injury. RPN #120 confirmed that they were expected to comment on all skin impairments on the weekly skin observation tool, noting whether they improved, worsened or healed, and did not do so on their assessment. Because of this, the status of the resident's skin was not clear at that time. RPN #120 also confirmed they discovered the worsened second wound and started a weekly skin observation tool at that time, but only included the worsened wound for monitoring, and not the specified permanent impairment. RPN #120 admitted that the specified permanent impairment should have been noted on the weekly skin observation tool as well.

RPN #135 confirmed they completed the head to toe assessment for resident #014 after the resident's second hospital visit and once they had the permanent impairment. RPN #135 confirmed that staff were expected to assess the resident's skin post hospitalization and indicate if the resident had any impaired skin integrity on the head to toe assessment form in PCC. If so, the staff were to initiate a new weekly skin observation tool at the same time as completing the head to toe assessment, and so that they could describe the skin impairment. This would allow all staff to appropriately monitor the resident's skin status. RPN #135 confirmed that they forgot to initiate a new weekly skin tool on their assessment of the resident. From what they were able to recall, RPN #135 believed the skin impairment that was noted at the time was the resident's permanently impaired site, and they did not recall any other skin impairments on the resident's body, including the second wound that was already discovered. RPN #135 confirmed they were expected to comment on all skin impairments on the weekly skin observation tool, noting whether they improved, worsened or healed, and did not do so on their assessment. Because of this, the status of the second wound was not clear at the time. RPN #135 also indicated that staff were expected to refer to the skin care lead and the dietitian for altered skin integrity and confirmed that they were supposed to refer to them for the new permanent impairment but forgot. In addition, RPN #135 confirmed it was their responsibility to initiate an order on the TAR for the permanent impairment so that staff could monitor it appropriately, but they forgot.

RN #121, the charge nurse for the home, indicated staff were expected to describe the status of the wound (i.e. improved, worsened or healed) on the weekly skin observation

tool whenever it was scheduled so that all staff were able to appropriately monitor the resident's skin status. RN #121 indicated these weekly skin observation tools would be initiated for any new skin conditions and would be scheduled weekly for reassessment until the skin condition resolved; at which point the RAI department would discontinue the scheduled weekly skin observation tool. RN #121 also indicated that the home recently initiated a new head to toe skin assessment tool and were expected to use the tool on admission, re-admission from hospital, quarterly assessments and upon significant change. Staff were to assess the resident's skin from head to toe and indicate if the resident had any impaired skin integrity on the head to toe assessment form in PCC, then if impaired skin integrity was found, initiate a new weekly skin observation tool. RN #121 also indicated that staff were expected to refer to the skin care lead and the dietitian for altered skin integrity. RN #121 confirmed none of these expectations were met in the above cases.

ADNC #147 was interviewed and indicated they were the skin care lead for the home and that they were responsible for following up on skin care lead referrals for all higher risk wounds, such as the ones discussed above. The RAI department (including RAI staff #151) assisted them in following up on other less significant wounds. ADNC #147 confirmed that they should have received a referral for resident #014's first wound when the staff first discovered the wound. They were only made aware of the wound three months later when they received a referral for the wound because it deteriorated. ADNC #147 indicated that they would have involved the ET nurse in the resident's wound care when the wound first developed, but that it was too late for the ET nurse to be involved when the wound was already deteriorated to a state requiring an invasive surgical procedure. ADNC #147 also confirmed that they were referred to assess the second wound when it was first discovered, and only followed up on the referral 13 days later because they were off for some of that time. On that assessment, ADNC #147 encouraged the staff to include all skin impairments on the weekly skin observation tool for resident #014 because they noticed this was not done. They also confirmed that they received another referral a few weeks later for the deteriorated second wound, but that RAI staff #151 followed up on the referral even though it was ADNC #147's responsibility. ADNC #147 indicated that if they had followed up on this referral, they would have involved the ET nurse in the resident's care for that wound as well.

RD #128 confirmed that they should have received a referral for the resident's first wound as indicated in the home's "Skin and Wound Care Program" policy (revised February 5, 2020), since it was an example of new altered skin integrity requiring a dietitian referral. RD #128 indicated that they were not aware of the resident's skin status

until they assessed the resident for an annual assessment four months later, when the resident returned from the hospital with a new permanent impairment. RD #128 acknowledged that they did not review the status of the resident's skin prior to this, and that the food service supervisor who completed quarterly assessments on the resident did not indicate that the resident had any skin concerns on their assessments throughout those four months despite the fact that the resident had the first wound during both those assessments. As the dietitian was only responsible to complete quarterly assessments on high risk residents, the food service supervisor continued to follow the resident instead and did not appropriately assess the resident's skin during their reviews. RD #128 then started following the resident more closely after completing the annual assessment. They acknowledged that if they were aware of the resident's first wound when it first developed, they would have changed the resident to high nutrition risk which would allow them to monitor the resident more closely.

Resident #014's physician (MD #145) confirmed that they were involved in the care of the resident's first wound but were surprised at how quickly the second wound deteriorated. MD #145 indicated the ET nurse should have been involved for the second wound but did not know why they were not involved. MD #145 indicated that involving the ET nurse was a team effort and that if the nursing staff didn't send a referral to the ET nurse, then they should have done so themselves. MD #145 believed that because the resident was back and forth in hospital, the second wound "fell off the radar". MD #145 believed that the second wound could have contributed to the resident's death.

B) Resident #014 who was exhibiting altered skin integrity did not receive a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

RPN #120 was interviewed and confirmed they completed the head to toe assessment for resident #014 when the resident came back from their first hospital visit. They did not initiate a new weekly skin observation tool together with the head to toe assessment because they thought the head to toe assessment was the only form requiring completion. RPN #120 stated that the weekly skin observation tool in PCC was the clinically appropriate assessment instrument that staff were expected to use for residents exhibiting altered skin integrity, and confirmed they did not use this tool during this incident.

RPN #135 indicated that they completed the head to toe assessment for resident #014 when the resident came back from their second hospital visit once they had a specified

permanent impairment, but forgot to initiate a new weekly skin observation tool. RPN #135 confirmed the scheduled weekly skin observation tool in PCC was the clinically appropriate assessment instrument that staff were expected to use for residents exhibiting altered skin integrity, but they did not use this tool during this incident.

ADNC #147, the skin care lead for the home, confirmed the scheduled weekly skin observation tool in PCC was the clinically appropriate assessment instrument that staff were expected to use for residents exhibiting altered skin integrity. The weekly skin observation tools were initiated for any new skin conditions and scheduled weekly for reassessment until the skin condition cleared, at which point the RAI department discontinued it. ADNC #147 also indicated that the home recently implemented a new head to toe assessment tool and were expected to use the tool on admission, re-admission from hospital, quarterly assessments and upon significant change. ADNC #147 confirmed staff did not use an appropriate assessment instrument to assess resident #014’s skin integrity in both of the above incidents.

C) Resident #014 who was exhibiting altered skin integrity was not assessed by the RD.

During review of resident #014’s clinical record, it was discovered that the dietitian last assessed the resident’s skin four months prior to the first wound being discovered, noting no nutritional concerns at the time and no need for supplementation. On a specified date, staff noted the first skin impairment discussed above. There was no dietitian referral made for this skin impairment. The food service supervisor conducted quarterly assessments for resident #014 twice over the next four months, and noted that the resident's skin was clear although the resident had ongoing weekly skin assessments and dressing changes for the first wound. The resident was deemed moderate nutrition risk on both occasions. Later, nursing staff found a new wound but no referral to the dietitian was completed. There were no dietitian assessments completed for resident #014 since the first wound was discovered until after the resident returned from their first hospital admission, and the dietitian assessed the resident but did not assess the resident’s skin status. It was not until the end of that month when the dietitian assessed the resident’s skin status during an annual nutrition review, and indicated the resident had a specified permanent impairment as well as noted the presence of a second wound. The dietitian then reassessed the resident a few days later, for a referral due to poor intake and started the resident on a nutritional supplement.

RD #128 stated that they should have been referred for both of the resident’s wounds when they were first discovered as indicated in the home’s “Skin and Wound Care

Program" policy (revised February 5, 2020), since these were examples of altered skin integrity requiring a dietitian referral. RD #128 indicated that they were not aware of the resident's skin status until they assessed the resident for an annual assessment when the resident returned from the hospital with the specified permanent impairment. They did not review the status of the resident's skin prior to this and the food service supervisor who completed quarterly assessments on the resident did not indicate that the resident had any skin concerns on their assessments despite the fact that the resident had the first wound during both those assessments. As the dietitian was only responsible to complete quarterly assessments on high risk residents, the food service supervisor continued to follow the resident instead and did not appropriately assess the resident's skin during their reviews. RD #128 then only started following the resident more closely after completing the annual assessment. RD #128 acknowledged that if they were aware of the resident's first wound, they would have changed the resident to high nutrition risk which would allow them to monitor the resident more closely.

D) Staff did not follow the home's policy under their skin and wound care program.

In accordance with O. Reg 79/10, s. 48 (1), the licensee was required to ensure a skin and wound care program was developed and implemented in the home to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Specifically, the staff did not comply with the licensee's "Skin and Wound Care Program" policy (revised February 5, 2020), which required the nursing staff to make referrals to the skin care lead using the Skin Care Lead Referral form in PCC and any other as needed. It also indicated that the nursing staff were to refer to the dietitian using the dietitian referral form for altered skin integrity such as the wounds discussed above. Further, the skin and wound care committee were to meet quarterly to discuss trends and analysis including successes/challenges; and for the skin and wound care lead to maintain a monthly tracking sheet for all wounds in the home (Village) to be distributed to neighbourhood coordinators, director of food services, registered dietitian, director of nursing care, and general manager. This monthly "Wound Care Tracking Sheet" was to be used on paper by the Skin Care Lead to oversee and support the program, or on the online skin and wound care tracker if available to the team (through the v: drive).

Staff failed to refer to the skin care lead and dietitian for both of the resident's wounds, resulting in late or lacking assessments of the resident's skin by the skin care lead and dietitian. Further review of the home's skin and wound care program indicated that there

were no records of the Wound Care Tracking Sheet available for inspector review going back to at least August 2019, and no records were available for any recent skin and wound care committee meetings.

RD #128 was interviewed and indicated that they were part of the skin and wound care committee however they had not attended a committee meeting for over eight months, nor received a copy of the Wound Care Tracking Sheet for approximately seven to eight months.

ADNC #147, the skin care lead for the home, was interviewed and indicated that they were currently in the process of filling in the information on the Wound Care Tracking Sheet for the missing months, using the available skin care lead referrals in PCC to display monthly wound information for residents in the home. ADNC #147 confirmed the wound tracking tool was not being used since at least August 2019. It would usually be used to monitor all the wounds in the home and be discussed at quarterly skin and wound care committee meetings. They did not recall the last time there was a skin and wound care committee meeting, and stated it was sometime in 2019, and there were no meetings held in 2020. ADNC #147 indicated that the home failed to follow the home's "Skin and Wound Care Program" policy because the staff did not refer to the skin care lead and dietitian when required, the skin care lead did not maintain the monthly wound tracking tool record, and the interprofessional team did not attend wound care committee meetings on a quarterly basis. [s. 48. (1) 2.]

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. 6. Plan of care

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

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

Resident #014's clinical records were reviewed due to complaints lodged with the MLTC regarding frequent falls, wound care, repositioning, bathing, hygiene care concerns, and alleged neglect for resident #014. The complainant was questioning whether staff were adequately bathing and repositioning resident #014; the complainant indicated the resident developed a large wound prior to their death that wasn't appropriately managed. The resident's records indicated that a wound in a specified location was discovered and the staff obtained a dressing order scheduled on the TAR; however there was no documentation on the status of the wound until almost a month later when a much larger wound was discovered by the staff during care provision.

A) Resident #014's records included a signed bathing preference consent form and a bathing focus on the resident's care plan in PCC. There was no direction on the resident's care plan on whether to shower or bathe the resident and when, until two weeks prior to their death, when the care plan was updated with the Substitute Decision Maker's (SDM's) request to provide a bed bath to the resident. There was no Point of

Care (POC) electronic task initiated or used for bathing for about a year prior to the resident's death.

PSW #110 was interviewed and confirmed that resident #014 did not have a task for bathing available to be completed in POC so they never documented when or how they provided bathing care for resident #014. Although the POC task for bathing was not available, PSW #110 insisted that they gave the resident a bed bath a day after the resident came back from hospital with a new specified permanent impairment as they thought the resident needed a “freshen up”. PSW #110 also recalled that they gave the resident a bed bath five days later as they were the ones that discovered the large wound and informed the registered staff. PSW #110 indicated they knew the resident and their bathing preferences as they were one of their regular staff, but they acknowledged that the lack of a POC task indicating the bathing preferences for resident #014 was an example of unclear directions to staff for the type of direct care the resident required.

RPN #113 confirmed that staff knew when to bathe, shower or bed bathe a resident according to the information provided in the bathing POC task. For example, if the resident required a shower or bath twice per week, such as on Tuesdays and Saturdays, the bathing task was scheduled in POC for those two days for staff to document on the completion of the task using the electronic tablet. This scheduled task also alerted the staff that the resident required a bath on that shift. RPN #113 acknowledged that the directions for resident #014’s bathing plan of care were unclear, especially for staff who didn’t typically care for resident #014. They also agreed that if the bathing task was missing from the resident’s POC records, there was a chance that the bathing task was not completed by staff because staff may have assumed the task was completed on another shift. However, they could not confirm that this occurred for resident #014.

ADNC #147 was interviewed and confirmed that staff knew the resident’s bathing needs from the bathing task that was created in POC. ADNC #147 was unsure if this task was completed for resident #014 at the times they required; they acknowledged the plan of care for resident’s bathing needs was unclear because the POC bathing task was never implemented for resident #014.

B) Resident #014’s care plan indicated that the resident required assistance with repositioning for approximately three to four weeks prior to their death. There was no POC task initiated for repositioning. An order to reposition the resident every two hours was started three days prior to their death, to be documented on the Medical Administration Record (MAR) on every shift.

PSW #108, one of the direct care staff involved in resident #014's care, was interviewed and indicated that resident #014 was less mobile when they returned from hospital around three to four weeks prior to their death, and required assistance with repositioning every two hours. PSW #108 confirmed that when a resident required repositioning assistance, a POC task for repositioning would be initiated in POC to alert the staff to document the task. PSW #108 indicated that all residents who were bedridden or required assistance with bed mobility required to be repositioned every two hours. They insisted that even if a POC task was not implemented, staff would have been aware of the resident's needs and repositioned the resident accordingly. PSW #108 insisted that staff would not have forgotten to reposition the resident when required based on standard nursing practice, however acknowledged that missing a POC task for repositioning was an example of unclear directions for the resident's plan of care.

RPN #120 was interviewed and confirmed they were the one who updated the resident's plan of care with the need to reposition the resident three to four weeks prior to their death. They did not initiate a POC task so that staff were triggered to reposition the resident and document the task. They did not know how to initiate a new POC task so they communicated the need to reposition the resident verbally to the team. RPN #120 also indicated that they placed a repositioning clock over the resident's bedside to indicate to staff that the resident required repositioning, but this clock was only implemented a week before the resident passed and when the resident wound had already deteriorated. They were unsure why the physician ordered repositioning on the MAR three days prior to the resident's death, but confirmed that this was not the home's usual practice. RPN #120 acknowledged that the missing POC task for repositioning and the inconsistent use of a repositioning clock were examples of unclear directions to the staff, for the type of care resident #014 required.

ADNC #147 was interviewed and confirmed that staff knew the resident's repositioning needs based on the repositioning task that was created in POC, which would trigger the staff to reposition the resident that required this assistance every two hours. ADNC #147 acknowledged missing a POC task for repositioning was an example of unclear directions to the staff for the type of care resident #014 required. ADNC #147 indicated that although staff used a repositioning clock for some residents requiring repositioning assistance, it was not used for all residents, and the POC task was the tool to use to ensure staff completed and documented on this task accordingly. [s. 6. (1) (c)]

2. As a result of non-compliance identified for resident #014, the sample was expanded

to include resident #015.

Record review indicated resident #015 required assistance from staff for most ADLs and were at risk of skin integrity issues related to their cognitive impairment, immobility and their multiple co-morbidities. Resident #015's care plan indicated the resident had a specified skin injury, and the care plan included several interventions to manage their increased risk of skin impairments, none of which were directly applicable to managing the specified skin injury. Resident #015's TAR orders were reviewed and indicated no current or recent wound treatments or wound monitoring were ordered for the resident.

Skin observation records were reviewed for the last three months. Of note, staff initiated a skin observation tool for the above skin injury on a specified date. Follow up skin observation tools were completed weekly for three weeks and indicated no skin impairments.

Resident #015 was observed by inspector #763 in their room during the inspection. A specified intervention for skin prevention was observed on another unrelated area of their body, and there were no visible signs of the previously mentioned skin injury.

PSW #123, the regular PSW for resident #015, was interviewed and confirmed the resident required assistance from staff for most ADLs including repositioning. PSW #123 indicated that resident #015 had no current skin concerns, but was using the intervention observed by inspector #763 for a while as they had a history of skin concerns on that area of the body.

RPN #144 was interviewed and indicated they were familiar with resident #015's care. They indicated that when a new skin impairment was discovered, staff were expected to start a new weekly skin observation tool and initiate a treatment on the Treatment Administration Record (TAR) for the skin impairment, to ensure it was monitored and treated until healed. Staff were to update the resident's care plan with the current state of their skin, and once healed, update the TAR and care plan with the status of the healed skin impairment. They were also to notify the RAI department so that the weekly skin observation tool would be discontinued. RPN #144 indicated the resident's care plan had to list any current treatments the resident was receiving related to skin care, and these treatments were to be included on the TAR, such as the intervention observed by inspector #763.

RPN #144 indicated they recently assessed resident #015 from head to toe and found no

skin impairments. RPN #144 was unsure why a weekly skin observation tool was still being scheduled for completion as there were no active skin impairments. RPN #144 indicated that the resident currently used the observed intervention on another unrelated area of their body, due to a history of skin impairments on that area. RPN #144 indicated there was a treatment for that area of the body on the TAR in the past, but it was discontinued when the wound healed.

RPN #144 confirmed the resident's care plan listed the previously mentioned specified skin injury as an active issue, but this should have been updated weeks before when the injury healed. In addition, RPN #144 confirmed the treatment for this injury was never added in the resident's care plan or the TAR; the weekly skin observation tool was the only intervention that was initiated to monitor the injury, and was not discontinued once it healed. They also indicated the intervention the inspector observed on the resident was not listed in the resident's plan of care, although it was an active intervention to prevent any future skin impairments. RPN #144 acknowledged that the resident's plan of care was unclear in providing the current status of the resident's skin, or the current interventions in place to manage the resident's impaired skin integrity. [s. 6. (1) (c)]

3. As a result of non-compliance identified for resident #014, the sample was expanded to include resident #016.

Record review indicated resident #016 required assistance from staff for most ADLs and was at risk of skin integrity issues related to their diagnosis. The resident's care plan included two focus items for skin - one indicating no current skin issues and the other indicating the resident had a chronic wound related to their impaired mobility. Resident #016's TAR orders indicated an unscheduled order for a skin injury on another part of their body, and for staff to follow 3M protocol for this wound; an order that was initiated two years earlier. There was also a scheduled order for a dressing on the wound that was included in the resident's care plan.

PSW #112 and PSW #146, the regular staff for resident #016, were observed providing care to the resident by inspector #763, and indicated that the resident's only current skin issue was a chronic wound as described in their care plan.

RPN #117 was interviewed and indicated they were familiar with resident #016's care. They confirmed resident #016's only current skin issue included the chronic wound. RPN #117 acknowledged that the resident's care plan had unclear information listed under the status of their skin, as the care plan stated there were no skin issues at present but also

had a separate focus that identified an active chronic wound. Additionally, RPN #117 indicated that the resident had a history of skin impairment on another part of the body, for which the SDM sometimes asked the staff to provide a specified intervention. RPN #117 confirmed the resident did not have a current skin impairment on this part of their body, but that the treatment order was left on the TAR from two years ago as a reminder to the staff that the SDM sometimes wanted the staff to provide the specified intervention. RPN #117 acknowledged there were no directions to staff anywhere in the resident's plan of care and no order about the SDM wishes for monitoring and providing the specified intervention if staff or SDM deemed it necessary. RPN #117 acknowledged that the wording of the TAR order for this area of the resident's body was unclear, as it made it appear as though resident #016 had a current wound and treatment orders for this area of the body when they did not. [s. 6. (1) (c)]

4. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of resident #014 so that their assessments were integrated, consistent with and complemented each other.

Resident #014's clinical records were reviewed due to complaints lodged with the MLTC regarding resident #014's care at the home. Resident #014 was admitted to the home with several diagnoses and conditions that put them at risk of falls, including diabetes. They used an assistive device for locomotion around their home unit but frequently forgot or did not want to use it, which often resulted in falls.

Resident #014's falls management records were reviewed for the nine months prior to their death, indicating a high rate of falls for the first two to three months reviewed. The falls occurred at various times of the day, on various shifts and in a variety of home areas. It was often noted that the resident's assistive device was either out of reach or not used by the resident at the time of the falls.

Resident #014's blood sugars were trending low throughout the first two months reviewed and staff also noted several incidences where the resident was noted to be drowsy, confused or sedated. Resident #014's blood sugars were checked once daily in the mornings and indicated that they also experienced episodes of hypoglycemia, including one incident in the first month and eight in the following month, occurring throughout the month.

Records indicated that the dietitian reviewed the resident's blood sugars two months prior to the period of frequent falls and found no concerns. The physician reviewed the

resident's frequent falls on several occasions during the two worst months, but there was no review of the resident's blood sugars. The Nurse Practitioner (NP) was asked to review the resident's falls at the end of the second month, at which point the NP suggested checking their blood sugar more frequently and to adjust their diet. The dietitian was also referred at this time and suggested the physician review the resident's diabetes medications, as well as adjusted their diet. At the end of the second month of frequent falls, the resident's SDM was concerned about the resident's low blood sugars, and the team left a note for the physician to assess the resident. The physician then assessed the resident's blood sugars in the context of their falls the following month, noting the blood sugars were trending low, so they decreased the doses of diabetes medications. The next dietitian review was around the same time, but there was no review of the resident's blood sugar status. The following month, the physician reassessed the resident's blood sugars and noted they continued to be trending low, so one of the resident's diabetes medications was discontinued. Approximately a month later, the physician noted the resident's blood sugars were now normal, and the resident was no longer experiencing frequent falls.

RPN #104 indicated that resident #014’s blood sugars trended low during the first two months reviewed. RN #104 confirmed that staff were expected to involve the physician in the resident’s care as soon as the resident showed signs of drowsiness, low blood sugar and episodes of hypoglycemia. RN #121 indicated that because resident #014 kept falling in those two months, the interventions in place to manage the resident’s falls at the time were not effective. There were also no changes in interventions to manage the resident’s falls until the NP, physician and dietitian assessed the resident for hypoglycemia the following month. RN #121 was not sure why it took so long for the staff to review the resident’s blood sugars as a potential cause for their frequent falls, and indicated this review should have occurred earlier.

RN #121 was interviewed and confirmed that staff were expected to involve the physician in the resident’s care as soon as the resident showed signs of drowsiness, low blood sugar and episodes of hypoglycemia. RN #121 indicated that because resident #014 kept falling in the first two months reviewed, the interventions in place to manage the resident’s falls at the time were not effective. There were also no changes in interventions to manage the resident’s falls until the NP, physician and dietitian assessed the resident for hypoglycemia the following month. RN #121 was not sure why it took so long for the staff to review the resident’s blood sugars as a potential cause for their frequent falls and indicated this review should have occurred earlier.

RD #128 confirmed they assessed the resident for their frequent falls in the context of their hypoglycemia at the end of the second month reviewed. RD #128 revised the resident's diet at the time and suggested the physician review their medication, but did not follow up on the status of the resident's blood sugars until six months later when they completed an annual assessment on the resident. They did not hear of any further concerns about the resident's hypoglycemia so assumed the resident was stable. RD #128 confirmed that it was part of dietetic best practice to follow up on the effectiveness of nutrition interventions after implementing a new intervention, and confirmed they failed to do this after revising the resident's diet.

MD #145 confirmed they were involved in resident #014's falls management while they were at the home and confirmed that their blood sugars were trending low at the time of their frequent falls in the first two months reviewed. MD #145 indicated that they only reviewed the resident's blood sugars the following month when the SDM was concerned about them, and acknowledged that a review of the resident's blood sugars and hypoglycemia should have happened earlier since resident #014 kept falling while experiencing multiple incidents of hypoglycemia. MD #145 indicated that staff should have notified them about the low blood sugars earlier and indicated there was a lack of staff collaboration in managing the resident's falls. [s. 6. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in ensuring that the plan of care sets out clear directions to staff and others who provide direct care to the resident; and that staff and others involved in the different aspects of care collaborate with each other in the assessment of residents so that their assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #3: 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 has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was in compliance with and was implemented in accordance with all applicable requirements under the Act.

In accordance with O. Reg. 79/10, s.68 (2) (b), the licensee was required to ensure the identification of any risk related to nutrition care and dietary services and hydration.

A complaint was reported to the MLTC related to concerns with resident #007's intake.

A review of the home’s policy titled Nutritional Care, under the home's Nutrition and Hydration, policy #07-24 reviewed on November 27, 2019, indicated below as follows:

-At the end of each day (24-hour period) the clinical software calculates all food and fluid consumed by the resident. The night RPN/RN will review the Look Back Report. Any resident that has a fluid intake less than their fluid requirements will be reported to the on-coming RPN/RN so that support strategies/ interventions can be initiated.
-The RPN/RN will assess for signs and symptoms of dehydration. If a resident exhibits one or more signs and symptoms of dehydration a dietitian referral is required with particular attention paid to the answering of the Hydration section in the referral.
-If a resident's fluid intake is less than 1000 mls for three consecutive days the resident will be referred to the RD.

A review of resident #007’s assessments in PCC indicated that no referral was sent to the RD when the resident's fluid intake was less than 1000 ml for three consecutive days, meeting less than half of the minimal requirement.

In an interview with RD #128, they acknowledged that they had not received a referral for resident #007 when their fluid intake was less than 1000 ml over three consecutive days during the above-mentioned period, therefore confirming that the home's policy was not followed.

In an interview with RPN #122, they acknowledged that the home's nutrition and hydration policy was not followed when resident #007's fluid intake over three consecutive days was less than 1000 ml and no referral was sent to the RD. The DNC #140 was informed of the non-compliance. [s. 8. (1) (a),s. 8. (1) (b)]

2. In accordance with O. Reg 79/10, s. 48 (1), the licensee was required to ensure a falls prevention and management program was developed and implemented in the home to reduce the incidence of falls and the risk of injury.

Specifically, the staff did not comply with the licensee's "Falls Prevention & Management Program [LTC]" policy (revised April 8, 2020), which required the PAL Kinesiologist/Exercise Therapist (or designate in homes (Villages)) to:

1. Track and trend all falls that occur each month in the Village.
2. Prepare a Monthly Falls Summary Report which details Village and neighbourhood trends. Share reports with neighbourhood teams through communication binder (or alternative) and discussions (huddles or falls committee if applicable).
3. Share a copy of the report with the leadership team for further discussion at the monthly risk management or BPR meeting.

The home's falls program was reviewed due to non-compliance found for resident #014 related to their falls management. There were no physical records available for the falls program for 2019. The monthly track and trends of falls (Risk Management Falls Report - LTC) were available in the home's electronic records. The falls huddle in-service sign-in records were reviewed - none were available for the 2019 year, and there were falls huddles held in 2020, including on February 5, August 18 and July 28.

DNC #140 and KIN #149 were interviewed and indicated that they were the new falls program leads for the home for the last two weeks. DNC #140 indicated that the previous falls program lead for the home shredded the 2019 falls binder when they left the facility, which included the home's records on any audits and education that was conducted as part of the falls program for that year; making it difficult for them to adequately review the falls program when they became the falls leads. DNC #140 indicated that the home had

the monthly tracking of falls in the home dating back to 2018, but confirmed that these reports were supposed to be discussed at huddles or falls committee meetings, and there were no records to support that these meetings were held in 2019. DNC #140 indicated that they held two falls huddles with the direct care staff since they became the falls leads for the program, however the only other falls huddle that was held in 2020 was in February by a previous falls program lead. DNC #140 acknowledged that it was expected to hold these falls huddles more frequently, and they had scheduled them regularly going forward. They also indicated that falls committee meetings should have been held in 2019 and 2020 but were not. DNC #140 indicated the previous falls program lead was sharing the monthly falls reports via email with the interdisciplinary team, but there was no opportunity to discuss the results of the reports with the team. DNC #140 indicated that some of this was due to the COVID-19 outbreak declared in the home in April 2020, but confirmed there were several months prior to April 2020 when the meetings should have been held and they were not. DNC #140 indicated a plan to hold future monthly falls committee meetings to better track and monitor the falls incidences in the home. [s. 8. (1) (a),s. 8. (1) (b)]

3. In accordance with O. Reg. 79/10, s.51 (2) (a), the licensee was required to ensure each resident who was incontinent received an assessment that included identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident required, an assessment was conducted.

A complaint was reported to the MLTC related to concerns with resident #007's continence changes.

A review of the home’s policy titled "Care", under the home's Continence Program, policy #04-29 reviewed on January 21, 2020, indicated that the resident’s continence was to be reassessed quarterly on the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment and on the Continence assessment annually and as needed (PRN) if there were changes to their continence status.

A review of resident #007’s assessments indicated that their last continence assessment was completed approximately two years prior to this inspection, and no other assessments were completed after as directed by the home's policy.

In an interview with resident #023, who sat at the same table with resident #007, they told the inspector that they observed resident #007 significantly soiled on several

occasions before the COVID-19 outbreak, when the resident's family visited after supper. Urine was observed in inappropriate areas of the resident's body.

In an interview with PSW #130, they told the inspector that eight out of 10 times when they came on shift, they would find resident #007 wet especially upon return from a recreation program.

In an interview with PSW #131, they told the inspector that they recalled being alerted by a co-worker that resident #007 required a continence change, as there was urine under the resident's assistive device.

In an interview with RPN #122, they acknowledged that the most recent continence assessment completed for resident #007 was two years prior to inspection. RPN #122 and DNC #140 both confirmed that the home's continence policy was not followed. [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 in ensuring that where the Act and Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any policy, the policy is complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident

under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Resident #014's clinical records were reviewed due to complaints lodged with the MLTC regarding frequent falls, wound care, repositioning, bathing, hygiene care concerns, and alleged neglect for resident #014. The complainant was questioning whether staff were adequately bathing and repositioning resident #014; the complainant indicated the resident developed a large wound prior to their death that wasn't appropriately managed. The resident's clinical records indicated that a wound in a specified location was discovered and the staff obtained a dressing order on the TAR, however there was no documentation on the status of the wound until almost a month later when a much larger wound was discovered by the staff during care provision.

Resident #014's clinical records included a signed bathing preference consent form and a bathing focus on the resident's care plan in PCC. There was no direction on the resident's care plan on whether to shower or bathe the resident and when, until two weeks prior to their death, when the care plan was updated with the Substitute Decision Maker's (SDM's) request to provide a bed bath to the resident. There was no Point of Care (POC) electronic task initiated or used for bathing for about a year prior to the resident's death. There was also no documentation noted of the resident's bathing care.

PSW #110 was interviewed and confirmed that resident #014 did not have a task for bathing available to be completed in POC, so they never documented when or how they provided bathing care for the resident. Although the POC task for bathing was not available, PSW #110 insisted that they performed an identified type of bathing activity on the resident a day after they came back from hospital with a specified permanent impairment, as they thought the resident needed a "freshen up". PSW #110 also recalled that they performed the same type of bathing activity five days later as they were they ones that discovered the large wound and informed the registered staff.

RPN #113 confirmed that staff knew when to bathe, shower or bed bathe a resident according to the information provided in the bathing POC task. For example, if the resident required a shower or bath twice per week, such as on Tuesdays and Saturdays, the bathing task was scheduled in POC for those two days for staff to document on the completion of the task using the electronic tablet. This scheduled task also alerted the staff that the resident required a bath on that shift. RPN #113 agreed that if the bathing task was not available in the resident's POC records, there was a chance that the bathing task was not completed by staff, because staff may have assumed the task was

completed on another shift. However, they could not confirm that this had occurred for resident #014.

ADNC #147 was interviewed and confirmed that staff knew the resident's bathing needs from the bathing task that was created in POC. ADNC #147 was unsure if this task was completed for resident #014 at the times they required, but acknowledged that the staff failed to document when the resident received an identified type of bathing activity because the POC task was never implemented for resident #014. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in ensuring that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin tears, was assessed by a registered dietitian who was a member of the staff of the home.

As a result of non-compliance identified for resident #014, the sample was expanded to include resident #015. Skin observation records were reviewed for the last three months. Of note, staff initiated a skin observation tool for a new skin injury for resident #015 on a specified date. A dietitian referral was not completed for this skin injury.

RPN #144 was interviewed and indicated they were familiar with resident #015's care at the home. RPN #144 indicated that skin impairments such as the one above were examples of altered skin integrity, but believed the registered dietitian only required a referral for altered skin integrity if they were nutritionally relevant, or severe enough warranting a referral. RPN #144 acknowledged they were not aware that the home's "Skin and Wound Care Program" policy (revised February 5, 2020) required the nursing staff to refer to the dietitian using the dietitian referral form for altered skin integrity, including the skin impairment indicated above. They confirmed staff should have referred to the dietitian so that an assessment by the dietitian would be completed.

RD #128 was interviewed and confirmed that they did not receive a referral for the above skin injury and indicated that staff were expected to refer for all altered skin integrity, as per the home's policy. RD #128 confirmed the last time they assessed the resident was two months prior to this skin injury, and had not assessed the resident's skin status since, despite the presence of a new skin impairment. [s. 50. (2) (b) (iii)]

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 in ensuring that a resident exhibiting altered skin integrity, including skin tears, is assessed by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

Issued on this 17th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	IANA MOLOGUINA (763), JULIEANN HING (649)
Inspection No. / No de l'inspection :	2020_833763_0014
Log No. / No de registre :	005954-20, 006166-20, 009703-20, 014450-20
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 9, 2020
Licensee / Titulaire de permis :	Schlegel Villages Inc. 325 Max Becker Drive, Suite. 201, KITCHENER, ON, N2E-4H5
LTC Home / Foyer de SLD :	The Village of Humber Heights 2245 Lawrence Avenue West, ETOBICOKE, ON, M9P-3W3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Pauline Dell'Oso

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Schlegel Villages Inc., you are hereby required to comply with the following order (s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 48. (1) Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home:

1. A falls prevention and management program to reduce the incidence of falls and the risk of injury.
2. A skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.
3. A continence care and bowel management program to promote continence and to ensure that residents are clean, dry and comfortable.
4. A pain management program to identify pain in residents and manage pain.

O. Reg. 79/10, s. 48 (1).

Order / Ordre :

The licensee must be compliant with s. 48. (1) of O. Reg. 79/10.

The licensee shall prepare, submit and implement a plan to ensure that the skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions, is implemented in the home.

The plan must include, but is not limited to, the following:

1. A process is developed to ensure that:

a) staff and others involved in the different aspects of care collaborate with each other in the assessment of altered skin integrity of residents so that their assessments are integrated, consistent with and complement each other;
b) residents exhibiting altered skin integrity receive a skin assessment by a member of the registered nursing staff using a clinically appropriate instrument specifically designed for skin and wound assessment;

c) residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, are assessed by the dietitian; and
d) the skin and wound care program is implemented according to the home's policies, including:
- ensuring staff refer to the skin care lead and dietitian for altered skin integrity
- the home to resume their skin and wound care committee meetings
- the skin and wound care lead to resume the maintenance of a monthly tracking sheet for all wounds in the home.

2. Staff members roles and responsibilities are identified for the implementation and evaluation of the above mentioned process.

3. A time line is established for the implementation of each component of steps a-d within the compliance due date.

Note: all components of the plan must be documented.

Submit the written plan, quoting inspection #2020_833763_0014 to Iana Mologuina, LTC Homes Inspector, by email to torontoSAO.moh@ontario.ca by October 26, 2020. Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee has failed to ensure that the skin and wound care program that promoted skin integrity; prevented the development of wounds and pressure ulcers; and provided effective skin and wound care interventions, was implemented in the home.

Resident #014's clinical records were reviewed due to complaints lodged with the Ministry of Long-Term Care (MLTC) regarding frequent falls, wound care, repositioning, bathing, hygiene care concerns, and neglect. The resident exhibited periods of altered skin integrity related to their falls history, age, and diagnosis. On a specified date, staff first noted a skin injury on the resident's scheduled weekly skin observation tool in Point Click Care (PCC) and a dressing order was implemented on the Treatment Administration Record (TAR). There were no referrals completed to the skin care lead or the registered dietitian (RD) for this wound. The wound continued to be noted on the scheduled weekly skin

observation tools for the next five to six months until the resident passed away. The observation tools indicated the location of the injury and that dressing and antibiotic orders were in place, but no description of its status.

A quarterly head to toe assessment was completed in PCC three months after the wound was first noted, indicating the resident had impaired skin integrity, but no description of the status of the skin impairment, and no weekly skin observation tool completed.

The first referral for the injury was submitted to the skin care lead three months after the wound was first discovered, when it was noted that the injury had deteriorated. The skin care lead called the resident's Substitute Decision Maker (SDM) to request consent for the Enterostomal Therapy (ET) nurse to assess the wound; the SDM declined since the resident was already scheduled for another appointment.

Staff submitted a referral to the skin care lead for a new wound approximately one week after. A dressing order was scheduled on the TAR. This referral was addressed by the skin care lead 13 days after the referral was originally submitted, and the skin care lead provided several recommendations, including encouraging the staff to initiate a weekly skin observation tool that assessed all current skin impairments. There was no referral to the RD noted. The resident was then admitted to hospital and staff completed a head to toe assessment in PCC upon the resident's return from the hospital. They indicated the resident had impaired skin integrity but did not initiate a skin observation tool to describe the type of impairment. There was no documentation completed on the status of the resident's new wound on their return from the hospital. The staff referred to the RD for the resident's return from hospital and the RD assessed the resident but did not assess their skin status. Another weekly skin observation tool was completed following the resident's hospital admission, which noted the size of the first wound and that there was no sign of infection; there was no note on the status of the second wound.

Resident #014 was admitted to the hospital once again for an emergency invasive surgical procedure; the resident came back to the home with a specified permanent impairment as a result of the first wound. Staff completed a head to toe assessment in PCC upon readmission to the home, indicating that resident

#014 had impaired skin integrity. Staff did not complete a weekly skin observation tool to describe the type of impairment, such as the specified permanent impairment. There were also no dressing orders started on the TAR for the impaired site. However, the RD assessed the resident's skin post hospitalization, noting the presence of the impaired site and the second wound that was originally mentioned by the staff on their referral to the skin care lead.

A few weeks later, staff completed a weekly skin observation tool indicating the second wound had grown significantly in size. There was no comment noted of the specified permanent impairment, but a referral was sent to the dietitian and the skin care lead for the worsened wound. Resident Assessment Instrument (RAI) staff #151 followed up on the skin care lead referral and provided several recommendations, including encouraging the staff to initiate a weekly skin observation tool that assessed all current skin impairments on the tool. No ET nurse involvement was considered at this time.

The RD was referred again a few days after due to the resident's declining intake and wound deterioration. The dietitian assessed the resident's skin status, weight and intake at the time, and increased the resident's supplement (which was started a few days earlier due to a referral for declined intake). The RD also changed the resident to high nutrition risk. A few days later, the resident passed away.

A) Staff and others involved in the different aspects of care failed to collaborate with each other in the assessment of resident #014 so that their assessments were integrated, consistent with and complemented each other.

RPN #104 reported that they were involved in resident #014's wound care, including completing several of the resident's scheduled weekly skin observation tools when the resident had the first injury. RPN #104 indicated staff were expected to describe the status of the wound (i.e. improved, worsened or healed) under the comments section of the tool so that all staff could appropriately monitor the resident's skin status. RPN #104 left that section blank when completing the weekly observation tools for resident #014 and did not remember why. RPN #104 also indicated that staff were expected to refer to the dietitian and skin care lead for altered skin integrity, and that they should have

been referred for this injury when it was first discovered.

RPN #113 confirmed they discovered the second wound. RPN #113 also referred to the skin care lead and started a new order on the TAR. RPN #113 did not know why the second wound was not reviewed on any following weekly skin assessments, or head to toe assessments, until the end of that month when staff discovered the wound was much larger. RPN #113 also indicated that they were expected to refer to the dietitian for this wound when it was first discovered but failed to do so. RPN #113 believed staff would be monitoring the wound in addition to the first wound on the already scheduled weekly skin observation tools, so they did not initiate another weekly skin observation tool. RPN #113 did not work with the resident again until the following month when the resident had already declined, and the larger wound was discovered.

RPN #120 confirmed they completed the head to toe assessment for resident #014 when the resident came back from their first hospital visit. RPN #120 confirmed that staff were expected to assess the resident's skin post hospitalization and indicate if the resident had any impairment in skin integrity on the head to toe assessment form in PCC. If so, the staff were expected to initiate a new weekly skin observation tool at the same time as completing the head to toe assessment. This would allow all staff to appropriately monitor the resident's skin status. RPN #120 confirmed that they did not initiate a new weekly skin tool because they thought the head to toe assessment was the only form requiring completion; it was the only form that was initiated by the RAI department for nursing staff to complete. After speaking with inspector #763, RPN #120 acknowledged it was their responsibility to initiate a weekly skin observation tool. From what they were able to recall, they were not aware of the second wound already discovered and believed the skin impairment that was noted on their head to toe assessment was the resident's first injury. RPN #120 confirmed that they were expected to comment on all skin impairments on the weekly skin observation tool, noting whether they improved, worsened or healed, and did not do so on their assessment. Because of this, the status of the resident's skin was not clear at that time. RPN #120 also confirmed they discovered the worsened second wound and started a weekly skin observation tool at that time, but only included the worsened wound for monitoring, and not the specified permanent impairment. RPN #120 admitted that the specified permanent impairment should have been noted on the weekly skin observation tool as well.

RPN #135 confirmed they completed the head to toe assessment for resident #014 after the resident's second hospital visit and once they had the permanent impairment. RPN #135 confirmed that staff were expected to assess the resident 's skin post hospitalization and indicate if the resident had any impaired skin integrity on the head to toe assessment form in PCC. If so, the staff were to initiate a new weekly skin observation tool at the same time as completing the head to toe assessment, and so that they could describe the skin impairment. This would allow all staff to appropriately monitor the resident's skin status. RPN #135 confirmed that they forgot to initiate a new weekly skin tool on their assessment of the resident. From what they were able to recall, RPN #135 believed the skin impairment that was noted at the time was the resident's permanently impaired site, and they did not recall any other skin impairments on the resident's body, including the second wound that was already discovered. RPN #135 confirmed they were expected to comment on all skin impairments on the weekly skin observation tool, noting whether they improved, worsened or healed, and did not do so on their assessment. Because of this, the status of the second wound was not clear at the time. RPN #135 also indicated that staff were expected to refer to the skin care lead and the dietitian for altered skin integrity and confirmed that they were supposed to refer to them for the new permanent impairment but forgot. In addition, RPN #135 confirmed it was their responsibility to initiate an order on the TAR for the permanent impairment so that staff could monitor it appropriately, but they forgot.

RN #121, the charge nurse for the home, indicated staff were expected to describe the status of the wound (i.e. improved, worsened or healed) on the weekly skin observation tool whenever it was scheduled so that all staff were able to appropriately monitor the resident's skin status. RN #121 indicated these weekly skin observation tools would be initiated for any new skin conditions and would be scheduled weekly for reassessment until the skin condition resolved; at which point the RAI department would discontinue the scheduled weekly skin observation tool. RN #121 also indicated that the home recently initiated a new head to toe skin assessment tool and were expected to use the tool on admission, re-admission from hospital, quarterly assessments and upon significant change. Staff were to assess the resident's skin from head to toe and indicate if the resident had any impaired skin integrity on the head to toe assessment form in PCC, then if impaired skin integrity was found, initiate a new

weekly skin observation tool. RN #121 also indicated that staff were expected to refer to the skin care lead and the dietitian for altered skin integrity. RN #121 confirmed none of these expectations were met in the above cases.

ADNC #147 was interviewed and indicated they were the skin care lead for the home and that they were responsible for following up on skin care lead referrals for all higher risk wounds, such as the ones discussed above. The RAI department (including RAI staff #151) assisted them in following up on other less significant wounds. ADNC #147 confirmed that they should have received a referral for resident #014's first wound when the staff first discovered the wound. They were only made aware of the wound three months later when they received a referral for the wound because it deteriorated. ADNC #147 indicated that they would have involved the ET nurse in the resident's wound care when the wound first developed, but that it was too late for the ET nurse to be involved when the wound was already deteriorated to a state requiring an invasive surgical procedure. ADNC #147 also confirmed that they were referred to assess the second wound when it was first discovered, and only followed up on the referral 13 days later because they were off for some of that time. On that assessment, ADNC #147 encouraged the staff to include all skin impairments on the weekly skin observation tool for resident #014 because they noticed this was not done. They also confirmed that they received another referral a few weeks later for the deteriorated second wound, but that RAI staff #151 followed up on the referral even though it was ADNC #147's responsibility. ADNC #147 indicated that if they had followed up on this referral, they would have involved the ET nurse in the resident's care for that wound as well.

RD #128 confirmed that they should have received a referral for the resident's first wound as indicated in the home's "Skin and Wound Care Program" policy (revised February 5, 2020), since it was an example of new altered skin integrity requiring a dietitian referral. RD #128 indicated that they were not aware of the resident's skin status until they assessed the resident for an annual assessment four months later, when the resident returned from the hospital with a new permanent impairment. RD #128 acknowledged that they did not review the status of the resident's skin prior to this, and that the food service supervisor who completed quarterly assessments on the resident did not indicate that the resident had any skin concerns on their assessments throughout those four months despite the fact that the resident had the first wound during both those

assessments. As the dietitian was only responsible to complete quarterly assessments on high risk residents, the food service supervisor continued to follow the resident instead and did not appropriately assess the resident's skin during their reviews. RD #128 then started following the resident more closely after completing the annual assessment. They acknowledged that if they were aware of the resident's first wound when it first developed, they would have changed the resident to high nutrition risk which would allow them to monitor the resident more closely.

Resident #014's physician (MD #145) confirmed that they were involved in the care of the resident's first wound but were surprised at how quickly the second wound deteriorated. MD #145 indicated the ET nurse should have been involved for the second wound but did not know why they were not involved. MD #145 indicated that involving the ET nurse was a team effort and that if the nursing staff didn't send a referral to the ET nurse, then they should have done so themselves. MD #145 believed that because the resident was back and forth in hospital, the second wound "fell off the radar". MD #145 believed that the second wound could have contributed to the resident's death.

B) Resident #014 who was exhibiting altered skin integrity did not receive a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument specifically designed for skin and wound assessment.

RPN #120 was interviewed and confirmed they completed the head to toe assessment for resident #014 when the resident came back from their first hospital visit. They did not initiate a new weekly skin observation tool together with the head to toe assessment because they thought the head to toe assessment was the only form requiring completion. RPN #120 stated that the weekly skin observation tool in PCC was the clinically appropriate assessment instrument that staff were expected to use for residents exhibiting altered skin integrity, and confirmed they did not use this tool during this incident.

RPN #135 indicated that they completed the head to toe assessment for resident #014 when the resident came back from their second hospital visit once they had a specified permanent impairment, but forgot to initiate a new weekly skin observation tool. RPN #135 confirmed the scheduled weekly skin

observation tool in PCC was the clinically appropriate assessment instrument that staff were expected to use for residents exhibiting altered skin integrity, but they did not use this tool during this incident.

ADNC #147, the skin care lead for the home, confirmed the scheduled weekly skin observation tool in PCC was the clinically appropriate assessment instrument that staff were expected to use for residents exhibiting altered skin integrity. The weekly skin observation tools were initiated for any new skin conditions and scheduled weekly for reassessment until the skin condition cleared, at which point the RAI department discontinued it. ADNC #147 also indicated that the home recently implemented a new head to toe assessment tool and were expected to use the tool on admission, re-admission from hospital, quarterly assessments and upon significant change. ADNC #147 confirmed staff did not use an appropriate assessment instrument to assess resident #014's skin integrity in both of the above incidents.

C) Resident #014 who was exhibiting altered skin integrity was not assessed by the RD.

During review of resident #014's clinical record, it was discovered that the dietitian last assessed the resident's skin four months prior to the first wound being discovered, noting no nutritional concerns at the time and no need for supplementation. On a specified date, staff noted the first skin impairment discussed above. There was no dietitian referral made for this skin impairment. The food service supervisor conducted quarterly assessments for resident #014 twice over the next four months, and noted that the resident's skin was clear although the resident had ongoing weekly skin assessments and dressing changes for the first wound. The resident was deemed moderate nutrition risk on both occasions. Later, nursing staff found a new wound but no referral to the dietitian was completed. There were no dietitian assessments completed for resident #014 since the first wound was discovered until after the resident returned from their first hospital admission, and the dietitian assessed the resident but did not assess the resident's skin status. It was not until the end of that month when the dietitian assessed the resident's skin status during an annual nutrition review, and indicated the resident had a specified permanent impairment as well as noted the presence of a second wound. The dietitian then reassessed the resident a few days later, for a referral due to poor intake and

started the resident on a nutritional supplement.

RD #128 stated that they should have been referred for both of the resident's wounds when they were first discovered as indicated in the home's "Skin and Wound Care Program" policy (revised February 5, 2020), since these were examples of altered skin integrity requiring a dietitian referral. RD #128 indicated that they were not aware of the resident's skin status until they assessed the resident for an annual assessment when the resident returned from the hospital with the specified permanent impairment. They did not review the status of the resident's skin prior to this and the food service supervisor who completed quarterly assessments on the resident did not indicate that the resident had any skin concerns on their assessments despite the fact that the resident had the first wound during both those assessments. As the dietitian was only responsible to complete quarterly assessments on high risk residents, the food service supervisor continued to follow the resident instead and did not appropriately assess the resident's skin during their reviews. RD #128 then only started following the resident more closely after completing the annual assessment. RD #128 acknowledged that if they were aware of the resident's first wound, they would have changed the resident to high nutrition risk which would allow them to monitor the resident more closely.

D) Staff did not follow the home's policy under their skin and wound care program.

In accordance with O. Reg 79/10, s. 48 (1), the licensee was required to ensure a skin and wound care program was developed and implemented in the home to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions.

Specifically, the staff did not comply with the licensee's "Skin and Wound Care Program" policy (revised February 5, 2020), which required the nursing staff to make referrals to the skin care lead using the Skin Care Lead Referral form in PCC and any other as needed. It also indicated that the nursing staff were to refer to the dietitian using the dietitian referral form for altered skin integrity such as the wounds discussed above. Further, the skin and wound care committee were to meet quarterly to discuss trends and analysis including successes/challenges; and for the skin and wound care lead to maintain a

monthly tracking sheet for all wounds in the home (Village) to be distributed to neighbourhood coordinators, director of food services, registered dietitian, director of nursing care, and general manager. This monthly "Wound Care Tracking Sheet" was to be used on paper by the Skin Care Lead to oversee and support the program, or on the online skin and wound care tracker if available to the team (through the v: drive).

Staff failed to refer to the skin care lead and dietitian for both of the resident's wounds, resulting in late or lacking assessments of the resident's skin by the skin care lead and dietitian. Further review of the home's skin and wound care program indicated that there were no records of the Wound Care Tracking Sheet available for inspector review going back to at least August 2019, and no records were available for any recent skin and wound care committee meetings.

RD #128 was interviewed and indicated that they were part of the skin and wound care committee however they had not attended a committee meeting for over eight months, nor received a copy of the Wound Care Tracking Sheet for approximately seven to eight months.

ADNC #147, the skin care lead for the home, was interviewed and indicated that they were currently in the process of filling in the information on the Wound Care Tracking Sheet for the missing months, using the available skin care lead referrals in PCC to display monthly wound information for residents in the home. ADNC #147 confirmed the wound tracking tool was not being used since at least August 2019. It would usually be used to monitor all the wounds in the home and be discussed at quarterly skin and wound care committee meetings. They did not recall the last time there was a skin and wound care committee meeting, and stated it was sometime in 2019, and there were no meetings held in 2020. ADNC #147 indicated that the home failed to follow the home's "Skin and Wound Care Program" policy because the staff did not refer to the skin care lead and dietitian when required, the skin care lead did not maintain the monthly wound tracking tool record, and the interprofessional team did not attend wound care committee meetings on a quarterly basis. [s. 48. (1) 2.]

The severity of this issue was determined to be a level 3 as there was actual risk to the resident. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 2 compliance history as there were

previous non-compliances issued to the home to different sections of the legislation - 50 Written Notifications (WNs), 22 Voluntary Plans of Correction (VPCs), and 7 Compliance Orders (COs). (763)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 9th day of October, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Iana Mologuina

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