Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: September 5, 2024

Inspection Number: 2024-1452-0003

Inspection Type:
Other
Complaint
Critical Incident

Licensee: Villa Colombo Seniors Centre (Vaughan) Inc.

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): July 9-12, 15-19, 22-26 and 29-31, 2024

The following intakes were completed in this Critical Incident (CI) inspection:

- Intake #00108475/CI #2969-000005-24, intake #00115856/CI # 2969-000037-24, Intake #00109980/CI #2969-000009-24, intake #00114519/CI #2969-000031-24, intake #00114845/CI #2969-000032-24, intake #00115062/CI #2969-000033-24, intake #00116497/CI #2969-000039-24, intake #00118618/CI #2969-000053-24, intake #00117073/CI #2969-000041-24 and intake #00118631/CI #2969-000054-24 were related to duty to protect.
- Intake #00110074/CI #2969-000008-24 and intake #00118413/CI #2969-000049-24 were related to improper care.
- Intake #00112328/CI #2969-000013-24 and intake #00112390/CI #2969-000014-24 were related to skin and wound care.
- Intake #00117369/CI #2969-000042-24 was related to infection prevention and control; and
- Intake #00121483 was related to Emergency Planning Attestation.

The following intake was completed in this complaint inspection:

- Intake #00118652 was related to duty to protect.

The following intakes were completed in this inspection:

- Intake #00112890/CI #2969-000018-24, intake #00114307/CI #2969-000026-24 and intake #00115373/CI #2969-000035-24 were related to Infection prevention and control.

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

Resident Care and Support Services
Skin and Wound Prevention and Management
Food, Nutrition and Hydration
Infection Prevention and Control
Safe and Secure Home
Prevention of Abuse and Neglect
Responsive Behaviours
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)

Non-compliance with: FLTCA, 2021, s. 3 (1) 19. iv.

Residents' Bill of Rights

s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

19. Every resident has the right to,

iv. have their personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to their records of personal health information, including their plan of care, in accordance with that Act.

The licensee has failed to ensure that residents had their personal health information (PHI) within the meaning of the Personal Health Information Protection Act, 2004, kept confidential.

Rationale and Summary

On July 11, 2024, a Registered Practical Nurse (RPN) left a computer that displayed residents' names and personal health information unattended in a resident home area (RHA). At the time, there were residents, staff, and family members in the immediate vicinity.

On July 18, 2024, a Student RPN left a computer that displayed residents' names and personal health information unattended another RHA. The screen was visible and accessible to residents and staff in the immediate vicinity.

Both staff acknowledged that they should have kept the computer screen hidden when unattended.

They immediately hid the screen after the breach was brought to their attention.

There was minimal risk to the residents as the breaches were immediately rectified.

Sources: Observation of computer screen on July 11 and 18, 2024, in two RHAs; interviews with staff.

Date Remedy Implemented: July 11 and 18, 2024.

NC #002 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (a)
Plan of care
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.

The licensee has failed to ensure that a planned care intervention was included in a resident's written plan of care.

Rationale and Summary

A resident had an intervention in place to prevent other residents from entering their room.

A Personal Support Worker (PSW), a RPN and a Registered Nurse (RN) acknowledged that the device was not included in the resident's written plan of care. The plan of care was revised to include the device on July 30, 2024.

There was no risk to the resident when the device was not included in their written plan of care as the intervention was implemented.

Sources: Resident's Clinical records; interviews with staff.

Date Remedy Implemented: July 30, 2024

NC #003 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (1) (c)
Plan of care

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,
(c) clear directions to staff and others who provide direct care to the resident.

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

Rationale and Summary

A resident was not to be offered certain food items at family request. The care plan directed staff not to provide one of the food items and the diet list directed staff to provide the food item.

The Nutrition Manager (NM) and Registered Dietitian (RD) both acknowledged that the care plan and diet list provided conflicting directions to staff. Both documents were immediately updated to provide clear directions.

There was no risk to the resident as the food items were not contraindicated and staff were aware of family request.

Sources: Resident 's care plan and diet list; interviews with staff.

Date Remedy Implemented: July 17, 2024

NC #004 remedied pursuant to FLTCA, 2021, s. 154 (2)
Non-compliance with: FLTCA, 2021, s. 6 (7)
Plan of care
s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan.

The licensee has failed to ensure that the care set out in the plan of care was provided to a resident.

Rationale and Summary

A resident was served incorrect food texture for dessert after a meal. The resident declined and staff cleared the table.

A PSW returned and served the appropriate food texture after they verified the resident's diet order with the Dietary Aide.

There was a risk that the resident would not have had a pleasurable dining experience when they were offered incorrect food texture.

Sources: Observations; Resident's clinical records, Interviews with staff.

Date Remedy Implemented: July 16, 2024

WRITTEN NOTIFICATION: Reporting certain matters to Director

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 28 (1) 2.
Reporting certain matters to Director
s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that an alleged physical abuse of a resident was reported to the Director immediately.

Rationale and summary

A resident's Substitute Decision Maker (SDM) informed a RPN that the resident received rough care from staff members. The home did not report the alleged abuse to the Director immediately.

The DOC and a RPN acknowledged that the concern should have been reported to the Director immediately.

Failure to report the alleged abuse of a resident resulted in the delayed follow up and investigation.

Sources: CIS #2969-000031-24, resident's health records, home's Zero Tolerance to Resident Abuse and Neglect policy (Policy #14147459, Last Revised 12/2022), interviews with a RPN and the DOC.

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 3 (1) 18.
Residents' Bill of Rights
s. 3 (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
18. Every resident has the right to be afforded privacy in treatment and in caring for their personal needs.

The licensee has failed to ensure that residents' right to be afforded privacy in treatment was fully respected and promoted.

Rationale and Summary

1) A RPN was observed administering treatments to two residents in the dining room during mealtime. Co-residents, staff members and caregivers were also present at the time.

The RPN and the DOC acknowledged that the residents were not afforded privacy when treatment was provided in the presence of other residents and staff members.

There was low risk and impact to the residents when treatment was provided in a public setting.

Sources: Observations; interviews with RPN and the DOC.

Rationale and Summary

2) On a separate day, a RPN was observed providing treatment to another resident in the dining room in full view of co-residents, staff, and family members.

The RPN acknowledged that they did not afford the resident privacy when they provided treatment in a public setting.

The home's medication pass policy directed nursing staff to ensure that privacy measures were always in place during medication pass, including administering medications in a manner and location that was respectful of the resident's privacy.

There was low risk and impact to the resident when treatment was provided in a public setting.

Sources: Observations; a review of the home's policy titled "The Medication Pass" revised June 30, 2023, interviews with RN and DOC.

WRITTEN NOTIFICATION: Plan of Care

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 6 (7)

Plan of care

s. 6 (7) The licensee shall ensure that the care set out in the plan of care is provided to

the resident as specified in the plan.

The licensee has failed to ensure that a resident's plan of care related to staff assistance was complied with.

Rationale and Summary

A resident required two staff assistance with a specific activity of daily living (ADL). On a specified day, the resident was reported with skin impairment of unknown cause. The home's investigation notes and interview with the PSW indicated that they assisted the resident with the specific ADL alone.

The Skin and Wound Lead stated the resident required two person staff assistance with the specific activity due to risk of skin impairment.

There was a risk of skin injury to the resident when staff did not provide the required assistance related to a specific ADL as specified in their plan.

Sources: Resident's written plan of care, home's Investigation notes; and interviews with staff.

WRITTEN NOTIFICATION: Plan of Care

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (10) (b)
Plan of care
s. 6 (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(b) the resident's care needs change or care set out in the plan is no longer necessary.

The licensee has failed to ensure that a resident was reassessed and their plan of care reviewed and revised when their care needs were no longer necessary.

Rationale and Summary

A resident's written plan of care indicated that they required the application of treatment devices. The resident was observed not wearing the treatment devices.

A PSW and RPN stated that the resident no longer required the treatment devices. Skin and wound lead stated that there was a change to the treatment and the resident's plan of care was not updated to reflect their current care needs.

When the resident's plan of care was not updated, there was a risk that their care needs were not being met.

Sources: Observations; written plan of care; and interviews with staff.

WRITTEN NOTIFICATION: Doors in a Home

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 12 (1) 3.
Doors in a home
s. 12 (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
3. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff.

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

Rationale and Summary

On July 11, 2024, the door leading into the spa room right next to the television (TV) room in a RHA was left unsupervised and ajar. The spa room held various items

including nail clippers, sharp containers, and razors. Residents were in the TV room with no staff supervision.

A RPN acknowledged that residents were not allowed in the spa room unsupervised, and the door should not have been left unsupervised while open.

The DOC acknowledged that the door to the spa room should have been closed and locked to prevent unsupervised access by residents.

Failure to secure non-residential areas put residents at risk of accidental injury from accessing unsupervised areas of the home.

Sources: Observations; interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 58 (4) (b)
Responsive behaviours
s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(b) strategies are developed and implemented to respond to these behaviours, where possible.

The licensee has failed to ensure that for residents who were demonstrating responsive behaviours, strategies were implemented to respond to their behaviours.

Rationale and Summary

1) A resident's plan of care indicated that they had a history of resisting care. Staff were directed to leave the resident and reapproach every five to ten minutes when they were triggered.

On a specified day, the resident was resistive to care and a PSW continued providing care while the resident called out and cried.

A RPN, RN and the DOC acknowledged that the PSW did not implement the strategies in place to manage the resident's responsive behaviours when they continued to provide the resident with care despite their resistance.

Failure to follow strategies outlined in the resident's plan of care to manage a known responsive behaviour, placed them at risk for harm and injury.

Sources: CI report #2969-000009-24, resident's clinical records, the home's investigation notes; and interviews with staff.

Rationale and Summary

2) A schedule was developed to manage a resident's specific responsive behavior.

One night, the resident wandered into another resident's room, exhibited the specific responsive behaviour and got into bed with the resident.

Two PSWs acknowledged that they did not follow the resident's care planned schedule on the night of the incident.

The DOC acknowledged that staff should have implemented the strategies developed to manage the resident's behaviour.

Failure to implement the plan outlined in the resident's plan of care to manage a known responsive behaviour, placed another resident at risk for harm and injury.

Sources: CI report #2969-000053-24, resident's clinical records, the home's investigation notes; and interviews with staff.

WRITTEN NOTIFICATION: Responsive Behaviours

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 58 (4) (c)

Responsive behaviours

s. 58 (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,

(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

The licensee has failed to ensure that when a resident demonstrated responsive behaviours, actions were taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions were documented.

Rationale and Summary

A resident was placed on Dementia Observation System (DOS) charting after resident-to-resident altercation, and to monitor the impact of treatment. The DOS tool was to be completed at 30-minute intervals to track and monitor the resident's responsive behaviours.

Three-week DOS charting showed 11 days out of the 21 days reviewed, had missing documentations of periods of up to 11.5 hours at a time.

A RN and ADOC the acknowledged that DOS charting for the resident was a component of their assessment and reassessment and should have been completed in its entirety. They confirmed that incomplete DOS charting could impact the ability to identify behaviour patterns and determine the impact and effectiveness of interventions.

Failure to complete DOS charting for a resident when they demonstrated responsive behaviours may have hindered their assessment and reassessment and staff's ability to evaluate resident's response to interventions.

Sources: A review of a resident's DOS charting; interviews with staff.

WRITTEN NOTIFICATION: Nutritional Care and Hydration Programs

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 74 (2) (e) (i)
Nutritional care and hydration programs
s. 74 (2) Every licensee of a long-term care home shall ensure that the programs include,
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter.

The licensee has failed to comply with the system to measure and record a resident's weight.

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure that there was a weight monitoring system to measure and record each resident's weight on admission and monthly thereafter and must be complied with.

Specifically, staff did not comply with the policy "Weight and Height Monitoring System", last revised January 1, 2024, which was included in the licensee's Nutrition and Hydration Program.

Rationale and Summary

A resident's weight record showed a weight loss of seven percent (%) body weight between January and February 2024. Staff did not comply with the policy and procedure for monitoring the resident's weight during this time.

Specifically, a nutritional referral was not submitted to the RD and a reweigh was not completed.

The homes weight monitoring policy directed staff to reweigh residents with a weight discrepancy of two Kilograms (kg) in one month, a weight change of five % in a month, and to notify the dietitian via referral.

A RPN, the RD and the DOC acknowledged that the resident should have been reweighed when their weight record indicated a weight loss of more than two kg and five % of their body weight in one month, and a referral should have been sent to the RD.

Failure to comply with the home's weight monitoring policy put the resident at health risks.

Sources: The home's policy " Weight and Height Monitoring System Policy" (#15089037 last revised 01/2024); the resident's clinical records; interviews with staff.

WRITTEN NOTIFICATION: Weight Changes

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 1.
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.

The licensee has failed to ensure that when a resident experienced a weight change of five percent % or more of their body weight over one month, they were assessed using an interdisciplinary approach, and that actions were taken, and outcomes were evaluated.

Rationale and Summary

A weight change of 10.3% in three weeks was recorded for a resident in May 2023. The significant weight change was not assessed, and outcomes of existing nutritional interventions were not evaluated as confirmed during an interview with the RD.

Between January and February of 2024, a resident's record showed a weight change of seven %. The significant weight change was not assessed by a RD as confirmed during an interview with the RD.

The RD and DOC acknowledged that an assessment should have been completed for the resident when they experienced a weight loss of more than five % in one month.

Failure to assess a resident for significant weight loss may have impacted the resident's health status and the ability to determine the effectiveness of existing dietary interventions.

Sources: Resident's Clinical record; and interviews with staff.

WRITTEN NOTIFICATION: Weight Changes

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 75 2.
Weight changes
s. 75. Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
2. A change of 7.5 per cent of body weight, or more, over three months.

The licensee has failed to ensure that when a resident experienced a weight change of 7.5 % or more of their body weight over three months, they were assessed using

an interdisciplinary approach, and that actions were taken, and outcomes were evaluated.

Rationale and Summary

In July 2023, a resident's recorded weight showed a weight change of 11.5% in three months. However, the significant weight change was not assessed by a RD as confirmed during an interview with the RD.

The RD and DOC acknowledged that an assessment should have been completed for the resident when they experienced a weight loss of more than seven point five % in three months.

Failure to assess a resident for significant weight loss may have impacted the resident's health status and the ability to determine the effectiveness of existing dietary interventions.

Sources: Resident's Clinical record; and interviews with staff.

WRITTEN NOTIFICATION: Dining and Snack Service

NC #015 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 79 (1) 9.
Dining and snack service
s. 79 (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
9. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.

The licensee has failed to ensure that three PSWs used proper techniques when assisting residents to eat.

Rationale and Summary

On two separate occasions, three PSWs stood over residents as they assisted them to eat and drink.

Two of the PSWs acknowledged that they should have been at eye level with the residents while assisting with eating, while the third PSW indicated that they were unaware of proper feeding techniques.

The RD confirmed that staff should sit and be at eye level when feeding to prevent choking and provide dignity to the residents.

Failure to ensure proper techniques when assisting residents with eating put them at risk of choking.

Sources: Observations; The home's policy titled "Eating Assistance" last revised August 2022; Interviews with staff.

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #016 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 246/22, s. 102 (2) (b)
Infection prevention and control program
s. 102 (2) The licensee shall implement,
(b) any standard or protocol issued by the Director with respect to infection prevention and control. O. Reg. 246/22, s. 102 (2).

The licensee has failed to ensure the additional requirements under the "IPAC Standard for Long-Term Care Homes April 2022" (IPAC Standard) were followed.

1) Specifically, the licensee did not ensure that the hand hygiene program included support for residents to perform hand hygiene prior to receiving meals and snacks as is required by Additional Requirement 10.4 (h) under the IPAC Standard.

Rationale and Summary

A PSW was observed bringing four residents into the dining room for meals. The residents were not assisted with hand hygiene prior to receiving their meals, and two of the residents ate independently.

The PSW acknowledged that they should have assisted the residents with hand hygiene prior to serving their meals and verified they failed to do so.

Failure to assist residents with hand hygiene prior to meals increased the risk of infectious disease transmission in the home.

Sources: Observations; IPAC Standard, April 2022, revised September 2023; interview with staff.

2) Specifically, the licensee did not ensure that IPAC training and education related to hand hygiene was provided to the caregiver of a resident as is required by additional requirement 7.1 (c) under the IPAC Standard.

Rationale and Summary

A Private Caregiver (PCG) was observed going in and out of a resident's room and providing direct care to the resident. They did not perform hand hygiene before and after resident and environment contact.

The PCG acknowledged that they started working with the resident the week prior and had not received education from the home on hand hygiene.

The IPAC Manager acknowledged that training on hand hygiene should have been provided to the PCG before they started working with a resident in the home.

Failure to educate a PCG working with a resident on hand hygiene posed a risk of disease transmission in the home.

Sources: Observations; IPAC Standard, April 2022, revised September 2023; interview with the PCG and IPAC Manager.

COMPLIANCE ORDER CO #001 Skin and Wound Care

NC #017 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 55 (2) (b) (iv)

Skin and wound care

s. 55 (2) Every licensee of a long-term care home shall ensure that,

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure injuries, skin tears or wounds,

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1. Review the home's Skin and Wound Policy with all registered staff on two RHAs;
2. Develop and implement an audit tool to ensure that two residents' skin impairments, are reassessed weekly by a member of a registered nursing staff as per the home's skin and wound policy. The audits should be conducted weekly for at least four weeks or longer until 100% compliance is reached;
3. Ensure that when a weekly skin and wound assessment is not completed as identified through the weekly audits, an assessment is completed as soon as the issue is identified; and
4. Maintain records in the home of the audits conducted, and the follow-up actions taken.

The licensee has failed to ensure that the weekly skin and wound assessments were completed for two residents.

Grounds

1) A resident was noted with a skin impairment on a specified date. There were no skin and wound assessments completed for the resident related to their skin impairment after the initial skin and wound assessment was completed.

A RPN stated that they did not complete a skin and wound assessment related to the resident's skin impairment when it was reported by a PSW. Another RPN stated that staff were expected to complete a weekly skin and wound assessment for any skin impairment until healed. The RPN and the home's Skin and Wound Lead confirmed that there was no further skin and wound assessment documented after the initial skin and wound assessment was completed.

There was a risk of delayed implementation of strategies to manage the resident's skin integrity when their weekly skin and wound assessments were not completed.

Sources: Resident's Skin and Wound Assessments, Home's Investigation Notes (February to March 2024), interviews with staff

2) On a specified date, documentation in the skin and wound app showed altered skin integrity on a specific area on the resident body. Infection originating around skin impairment progressed to the surrounding areas in three months, despite ongoing treatments. However, the skin impairment was not reassessed weekly by the registered staff using the skin and wound evaluation assessment for 21 weeks.

On a specified day, skin impairment in another area of the resident's body was documented in the skin and wound app. The area of impairment deteriorated four months later despite ongoing treatments. The weekly skin and wound assessments related to the area of skin impairment was missed for four weeks.

The RPN stated that all types of skin impairments were expected to be assessed weekly using the weekly skin and wound evaluation until the wound was healed. The ADOC stated that staff were expected to complete weekly skin and wound

assessments in the electronic record. The Skin and Wound Lead confirmed that the weekly skin and wound assessments related to the resident's skin impairment were missed.

When the home failed to consistently complete the weekly skin and wound assessments for a resident, the effectiveness of treatment evaluation was missed and caused further injury.

Sources: Skin Integrity Program Overview LTC (August 2023), resident's Skin and Wound Assessments, interviews with staff.

This order must be complied with by October 14, 2024

REVIEW/APPEAL INFORMATION

TAKE NOTICE The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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