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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 14, 2020	2020_829757_0017 (A1)	006726-20	Complaint

Licensee/Titulaire de permis

Riverside Health Care Facilities Inc.
110 Victoria Avenue FORT FRANCES ON P9A 2B7

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

Rainycrest
550 Osborne Street FORT FRANCES ON P9A 3T2

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

Amended by DAVID SCHAEFER (757) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

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

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This public inspection report has been revised to reflect an extension to the compliance due date for orders #001 & #002 to allow the home to achieve sustainable compliance. The Complaint inspection, #2020_829757_0017 was completed on July 27-31, 2020.
A copy of the revised report is attached.

Issued on this 14th day of October, 2020 (A1)

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

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

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

Amended by DAVID SCHAEFER (757) - (A1)

Amended 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): July 27-31, 2020.

The following intake was inspected during this Complaint inspection:

-A complaint related to resident care concerns regarding the provision of dietary services and skin and wound care, as well as concerns regarding the cleanliness of the home.

This inspection was conducted concurrently with Critical Incident System inspection #2020_829757_0018.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Clinical Manager, Registered Nurses (RNs), Registered Practical Nurse (RPN), Health Care Aides (HCAs), and residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Skin and Wound Care

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

4 WN(s)
1 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #004 was not neglected by the licensee or staff.

Neglect, as defined in Ontario Regulation (O. Reg.) 79/10, means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's policy "Abuse and Neglect Zero Tolerance Policy - ORG-RES-LTC-A-05", effective April 11, 2018, stated that the home was "committed to providing an environment of zero tolerance of abuse or neglect of residents by any person". The policy's appendix C titled "Possible Signs of Abuse or Neglect", provided a specified type of wound that was "undetected or untreated", as an example of neglect.

The home's policy "Skin and Wound Program: Prevention of Skin Breakdown - RC-23-01-01", last updated December 2019, stated that care staff were to, daily on all shifts, "observe residents' head to toe skin condition, including heels, elbows, back of head and other pressure points, during the provision of personal care", "document altered skin integrity in Daily Care Record or electronic equivalent", and "promptly report verbally any changes … to the nurse". The policy stated that nursing staff were to then "promptly assess/address all skin concerns reported by the care staff".

Inspector #757 conducted a review of resident #004's electronic health records. The Inspector noted two assessments from a specified date in February 2020, which were titled "Skin - Wound Assessment - PUSH". Both assessments stated that they were the "initial" assessment, indicating "new wound, no previous assessment". The assessment for "Wound 01" indicated that the wound had been acquired in the home, and was classified as the specified type of wound identified in appendix C titled "Possible Signs of Abuse or Neglect". The assessment for "Wound 02" indicated that the wound had been acquired in the home, and was classified as the same type of wound. Both assessments indicated that the wounds were a moderate size and that the tissue type in the wound beds indicated a significant alteration of the resident’s skin integrity. The record review did not locate any assessments or progress notes related to the identification or assessment of these wounds prior to the specified date in February 2020.

The Inspector reviewed the home's electronic POC Records for the period of January 1, 2020, to the specified date of assessment in February 2020, related to the provision of care of resident #004. Under the heading of "MONITOR - Skin Observation", the POC system prompted the HCAs each shift to answer the question "Does the Resident have a NEW skin issue?", and provide the classification of skin observation if a new skin issue was identified. All entries over the identified time period indicated that there had been no new skin issues identified for the resident.

During an interview with the home's Wound Care Lead, they indicated that new skin and wound issues were expected to be identified by HCAs in the electronic POC system. The Wound Care Lead stated that baths were provided to residents twice weekly by HCAs, that skin condition should have been assessed at that time, and any significant changes reported to the registered staff in order to prompt an assessment. They stated that they "really rely on HCAs to let us know when there are skin issues". The Wound Care Lead indicated that by the time resident #004’s wounds had reached the size that they were on the specified date in February 2020 when the wounds were initially assessed, with the tissue type indicating a significant alteration in skin integrity, that they would have presented for some time before being identified. They added that the HCA staff should have identified this issue and brought it to the attention of the registered nursing staff much earlier.

An electronic progress note written by resident #004's physician read: "THIS IS NOT ACCEPTABLE ... THIS WAS PREVENTABLE AND SHOULD NOT HAPPEN".

During an interview with the home's Administrator they stated that by the time resident #004's wounds had progressed to the state that they were assessed at on the specified date in February 2020, that they would have been present for some time, and should have been noted prior. The Administrator indicated that staff did not follow the home's Skin and Wound Program policies, and that the issue should have been brought to the attention of nursing staff earlier, stating "You don’t just show up at [significantly altered skin integrity], so somewhere along the line someone did not follow up and alert". They further stated that the failure to identify the change in resident #004's skin condition, leading to the development of the wounds, was neglect. [s. 19. (1)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

WN #2: 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 where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee ensured that the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 2., the licensee was required to ensure that 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 was implemented in the home. In reference to O. Reg. 79/10, s. 50 (2) (b) (i), the program was required to ensure that a resident

exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

In accordance with the Long-Term Care Homes Act (LTCHA), 2007, s. 11 (1) (a), the licensee was required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. Pursuant to O. Reg. 79/10, s. 68 (2) (a), the program was required to ensure the programs included the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration. In reference to O. Reg. 79/10, s. 68 (2) (b), the programs were required to include the identification of any risks related to nutrition care and dietary services and hydration.

Specifically, staff did not comply with the home’s policies titled "Skin and Wound Program: Prevention of Skin Breakdown - RC-23-01-01" and "Skin and Wound Program: Wound Care Management - RC-23-01-02".

The home's policy "Skin and Wound Program: Prevention of Skin Breakdown - RC-23-01-01", last updated December 2019, stated that care staff were to, daily on all shifts, "observe residents' head to toe skin condition, including heels, elbows, back of head and other pressure points, during the provision of personal care", "document altered skin integrity in Daily Care Record or electronic equivalent", and "promptly report verbally any changes … to the nurse". The policy stated that nursing staff were to then "promptly assess/address all skin concerns reported by the care staff". Once skin issues were identified, the policy indicated that the nursing staff were to conduct a head to toe assessment and implement a comprehensive plan of care including interventions to address risk factors associated with skin breakdown.

The home's policy "Skin and Wound Program: Wound Care Management - RC-23 -01-02", last updated December 2019, stated that care staff were to "promptly report changes in skin integrity observed during daily care and weekly bath/shower to the Nurse for immediate assessment" and "document altered skin integrity as per home's process. In homes with Point of Care (POC) tablets, the care staff will document by exception once a shift". The policy stated that nursing staff were to "promptly assess all residents exhibiting altered skin integrity on

initial discovery", and "generate individualized resident plans of care" and use these to "implement preventative measures, treat healable and non-healable wounds, or for management of palliative wounds".

The home's policy "Nutritional Assessments - NC-04-01-03", last updated March 2020, stated that the Registered Dietitian (RD) was to complete a nutritional assessment on every resident whenever a significant change in the resident's health condition had nutritional implications. The policy indicated that upon referral or worsening condition, the appropriate assessment in the appendix should be completed, as needed.

a) A complaint was received by the Director related to the provision of skin and wound care to resident #002.

A review of resident #002's electronic POC records for March 2020, noted that a new skin issue had been identified for resident #002 by an HCA on a specified date in March 2020. The new skin issue was classified as an early stage of altered skin integrity. Four days later, the POC documentation identified that an additional skin change was noted, indicating that the area had further deteriorated, and that multiple wounds were present.

Inspector #757 conducted a review of resident #002's electronic health records. An assessment titled "Skin - Impaired Skin Integrity Assessment" was conducted by the home on the same day that the area of altered skin integrity was noted to have deteriorated. The assessment identified the presence of multiple wounds, and indicated that they had been cleansed, a treatment applied, and that referrals were made to the Registered Dietitian (RD) and Nurse Practitioner (NP).

No skin/wound assessments or progress notes related to the resident's impaired skin integrity could be identified on the specified date in March 2020, when the initial change in skin condition had been documented.

A clinical note from a later specified date in March 2020, written by NP #109, indicated that the resident's wound had progressed significantly. An electronic wound note from the same date, indicated that the wound size had increased, and indicated that the type of tissue in the wound had deteriorated. Progress notes indicated that the resident was also being treated for other wounds which had developed. A progress note from a specified date in April 2020, written by NP #109, identified that resident #002 had multiple risk factors that predisposed them

to non-healing wounds.

During an interview conducted with HCA #103, they stated that they were the first staff member to note the change in the resident's skin condition, noting that it was a small area at the time. The HCA indicated that when HCAs noted these skin changes, in addition to documenting the change electronically in POC, they would provide a verbal report to the Registered Nurse (RN), Registered Practical Nurse (RPN), or Unit Coordinator. The HCA indicated that they had provided a verbal report regarding the change in resident #002's skin integrity. The HCA further indicated that when a change in skin condition was noted in POC, an electronic alert was automatically generated for the nursing staff to follow up.

The home's Wound Care Lead confirmed that when the HCA staff documented a change in skin condition in the electronic POC system, an alert would have been created, and one of the home's nursing staff would have seen the notification.

The Inspector conducted an interview with the home's Administrator. They stated that there should have been a skin assessment for resident #002 after the new skin issue was initially identified in March 2020. The Administrator stated that the staff did not follow the home's policy to "promptly assess/address all skin concerns reported by the care staff", and indicated that the delay in assessment and subsequent treatment could have contributed to the initial development of the resident's wounds.

b) A complaint was received by the Director related to the provision of dietary services to resident #002.

During an interview with HCA #103, they stated that in January 2020, they had reported to an RN, RPN, and RD #106 that they had observed resident #002 demonstrating a specified behaviour that indicated a risk for certain dietary issues.

Inspector #757 conducted a review of resident #002's electronic progress notes. A progress note from March 2020, written by RN #108, noted that the resident had again been noted to be demonstrating the specified dietary behaviour, and indicated that a referral to RD #106 was made as a result. A progress note from the following day, written by RD #106, indicated that they were following up regarding the resident's behaviour, but that a specified assessment had not been completed, noting that it was not completed as the resident had an illness at the

time. The note also stated that the resident was to be provided with specified textures for food and fluids.

Progress notes from April 2020, indicated that the resident had continued to be observed demonstrating the specified dietary behaviour, and was also demonstrating additional dietary concerns which further indicated dietary risks.

The specified assessment which had not been completed previously, was conducted by RD #106 in April 2020, approximately one month after the assessment was initially to be conducted. The assessment identified that the resident was experiencing additional dietary concerns. A progress note related to the assessment indicated that the resident required a significant change to their dietary care as a result of the assessment.

During an interview conducted with RD #106, they stated that residents who demonstrated the same specified dietary behaviour as resident #002 were at risk for certain dietary issues. The RD noted that when these behaviours presented in a resident, they would want to assess the resident and make any changes required to their care. The RD indicated that at the time the specified assessment the resident was initially referred for in March 2020, the home was encouraging staff to limit non-essential resident interactions. They also indicated that this type of assessment should have been completed as soon as the issues were identified, and that it was an essential assessment. The RD further stated that a resident who had dietary issues similar to resident #002’s was at risk for multiple significant complications. The RD stated that the ordering of a specified diet texture in March 2020 could have posed a risk for the resident experiencing certain complications, and that if they had completed their assessment at that time, and noted the issues, they would have changed the order. They stated "I would say definitely it was a possibility that [the dietary order and the delayed assessment] could have contributed to [the resident's] decline. That’s an area we could have done better".

Inspector #757 conducted an interview with the home's Administrator, where they indicated that RD #106 could have donned personal protective equipment and completed the specified assessment in March 2020, despite the resident's illness at the time. The Administrator stated that the home's policy to complete a nutritional assessment, including the specified assessment, whenever a significant change in a resident's health condition which had nutritional implications presented, was not followed.

c) Inspector #757 conducted a review of resident #004's electronic health records. The Inspector noted two assessments from a specified date in February 2020, which were titled "Skin - Wound Assessment - PUSH". Both assessments stated that they were the "initial" assessment, indicating "new wound, no previous assessment". The assessment for one wound indicated that the wound had been acquired in the home, and was classified as a specified type of wound. The assessment for another wound indicated that the wound had been acquired in the home, and was classified as the same type of wound. Both assessments indicated that the wounds were a moderate size and that the tissue type in the wound beds indicated a significant alteration of the resident’s skin integrity. The record review did not locate any assessments or progress notes related to the identification or assessment of these wounds prior to the specified date in February 2020.

The Inspector reviewed the home's electronic POC Records for the period of January 1, 2020, to the specified date of assessment in February 2020, related to the provision of care of resident #004. Under the heading of "MONITOR - Skin Observation", the POC system prompted the HCAs each shift to answer the question "Does the Resident have a NEW skin issue?", and provide the classification of skin observation if a new skin issue was identified. All entries over the identified time period indicated that there had been no new skin issues identified for the resident.

During an interview with the home's Wound Care Lead, they indicated that new skin and wound issues were expected to be identified by HCAs in the electronic POC system. The Wound Care Lead stated that baths were provided to residents twice weekly by HCAs, that skin condition should have been assessed at that time, and any significant changes reported to the registered staff in order to prompt an assessment. They stated that they "really rely on HCAs to let us know when there are skin issues". The Wound Care Lead indicated that by the time resident #004’s wounds had reached the size that they were on the specified date in February 2020 when the wounds were initially assessed, with the tissue type indicating a significant alteration in skin integrity, that they would have presented for some time before being identified. They added that the HCA staff should have identified this issue and brought it to the attention of the registered nursing staff much earlier.

During an interview with the home's Administrator they stated that by the time

resident #004's wounds had progressed to the state that they were assessed at on the specified date in February 2020, that they would have been present for some time, and should have been identified prior. The Administrator indicated that staff did not follow the home's Skin and Wound Program policies, and that the issue should have been brought to the attention of nursing staff earlier, stating "You don't just show up at [significantly altered skin integrity], so somewhere along the line someone did not follow up and alert". [s. 8. (1) (b)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On July 29, 2020, Inspector #757 observed that the home's east unit clean utility room had been left unattended with no staff in the room or immediate area, and the door had been left propped open. There were two residents directly outside of the room. The clean utility room contained three electrical service panels, one of which had no lock and was open and accessible, and another which had a lock installed but was left unlocked and accessible. Each panel had a label which read “CAUTION”.

During an interview conducted with HCA #103, they confirmed that the clean utility room door had been left open, and that it should have been closed and locked.

The Inspector conducted an interview with the home's Administrator, where they confirmed that the door to the clean utility room was required to be closed and locked when not being supervised by staff. They further indicated that the access to electrical panels constituted a potential hazard for residents, and that the panels would be promptly repaired and locked. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that for every written or verbal complaint made to the licensee concerning the care of a resident, the complaint was investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint.

A complaint was received by the home, related to the provision of wound care to resident #002. Part of the complaint was related to concerns related to a specified skin issue.

The home's policy "Rainycrest Long Term Care Complaints/Concerns Process - P-VI-3", stated that "all complaints, whether verbal or written from residents, families, visitors and staff will be investigated and actions taken for resolution within 10 business days". The policy also indicated that "the administrator or designate will investigate all verbal and written forms of complaint and provide response to complainant within the prescribed time".

The home's notes related to the complaint indicated that an interview was conducted with the home's previous Administrator and the complainant. The interview notes indicated that the complainant had concerns about the resident's skin issue and that they had requested to have the issue evaluated three weeks prior. The notes stated that the home reassured the complainant that an investigation would be commenced immediately.

The Inspector conducted a review of the home's investigation file into the complaint. The file did not contain any further reference to the resident's specified skin issue following the home's initial information gathering interview with the

complainant. A review of the resident's progress notes over a specified time period did not locate any mention of the skin issue.

The home sent a letter of response to the complainant to provide a summary of the information related to the home's investigation into the complaint. The letter detailed the home's investigation into the complainant's concerns related to the provision of wound care to resident #002, but did not address the concerns related to the specified skin issue.

During an interview conducted with the home's Administrator, they indicated that while the concerns related to the specified skin issue had been discussed by the home's previous Administrator during the initial interview with the complainant, the home's investigation notes and the home's response letter to the complainant did not include any mention of the skin issue or indicate any investigation into that complaint. [s. 101. (1) 1.]

Issued on this 14th day of October, 2020 (A1)

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DAVID SCHAEFER (757) - (A1)
Inspection No. / No de l'inspection :	2020_829757_0017 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	006726-20 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 14, 2020(A1)
Licensee / Titulaire de permis :	Riverside Health Care Facilities Inc. 110 Victoria Avenue, FORT FRANCES, ON, P9A-2B7
LTC Home / Foyer de SLD :	Rainycrest 550 Osborne Street, FORT FRANCES, ON, P9A-3T2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Taralee Morelli

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 Riverside Health Care Facilities 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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee must:
A) Ensure all residents are protected from neglect by the licensee or staff.

B) Provide and maintain records of training to all staff on the definition of neglect (as defined in O. Reg. 79/10, s. 5), providing examples of neglect as it pertains to various roles in the home, and the responsibility of all staff related to the prevention, recognition, response, and reporting of neglect.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #004 was not neglected by the licensee or staff.

Neglect, as defined in Ontario Regulation (O. Reg.) 79/10, means the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The home's policy "Abuse and Neglect Zero Tolerance Policy - ORG-RES-LTC-A-05", effective April 11, 2018, stated that the home was "committed to providing an environment of zero tolerance of abuse or neglect of residents by any person". The policy's appendix C titled "Possible Signs of Abuse or Neglect", provided a specified type of wound that was "undetected or untreated", as an example of neglect.

The home's policy "Skin and Wound Program: Prevention of Skin Breakdown - RC-23-01-01", last updated December 2019, stated that care staff were to, daily on all shifts, "observe residents' head to toe skin condition, including heels, elbows, back of head and other pressure points, during the provision of personal care", "document altered skin integrity in Daily Care Record or electronic equivalent", and "promptly report verbally any changes … to the nurse". The policy stated that nursing staff were to then "promptly assess/address all skin concerns reported by the care staff".

Inspector #757 conducted a review of resident #004's electronic health records. The Inspector noted two assessments from a specified date in February 2020, which were titled "Skin - Wound Assessment - PUSH". Both assessments stated that they were the "initial" assessment, indicating "new wound, no previous assessment". The assessment for "Wound 01" indicated that the wound had been acquired in the home, and was classified as the specified type of wound identified in appendix C titled "Possible Signs of Abuse or Neglect". The assessment for "Wound 02" indicated that the wound had been acquired in the home, and was classified as the same type of wound. Both assessments indicated that the wounds were a moderate size and that the tissue type in the wound beds indicated a significant alteration of the resident’s skin integrity. The record review did not locate any assessments or progress notes related to the identification or assessment of these wounds prior to the specified date in February 2020.

The Inspector reviewed the home's electronic POC Records for the period of January 1, 2020, to the specified date of assessment in February 2020, related to the provision of care of resident #004. Under the heading of "MONITOR - Skin Observation", the POC system prompted the HCAs each shift to answer the question "Does the Resident have a NEW skin issue?", and provide the classification of skin observation if a new skin issue was identified. All entries over the identified time period indicated that there had been no new skin issues identified for the resident.

During an interview with the home's Wound Care Lead, they indicated that new skin and wound issues were expected to be identified by HCAs in the electronic POC system. The Wound Care Lead stated that baths were provided to residents twice weekly by HCAs, that skin condition should have been assessed at that time, and any significant changes reported to the registered staff in order to prompt an assessment. They stated that they "really rely on HCAs to let us know when there

are skin issues". The Wound Care Lead indicated that by the time resident #004's wounds had reached the size that they were on the specified date in February 2020 when the wounds were initially assessed, with the tissue type indicating a significant alteration in skin integrity, that they would have presented for some time before being identified. They added that the HCA staff should have identified this issue and brought it to the attention of the registered nursing staff much earlier.

An electronic progress note written by resident #004's physician read: "THIS IS NOT ACCEPTABLE ... THIS WAS PREVENTABLE AND SHOULD NOT HAPPEN".

During an interview with the home's Administrator they stated that by the time resident #004's wounds had progressed to the state that they were assessed at on the specified date in February 2020, that they would have been present for some time, and should have been noted prior. The Administrator indicated that staff did not follow the home's Skin and Wound Program policies, and that the issue should have been brought to the attention of nursing staff earlier, stating "You don't just show up at [significantly altered skin integrity], so somewhere along the line someone did not follow up and alert". They further stated that the failure to identify the change in resident #004's skin condition, leading to the development of the wounds, was neglect.

The decision to issue a Compliance Order (CO) was based on the severity of the issue, which was a level 3, indicating that there was actual harm to a resident. The scope of the issue was a level 1, indicating that the issue was isolated. The home's compliance history for the issue was a level 3, indicating previous non-compliance to the same subsection:
- CO #004 issued August 17, 2018, in inspection report #2018_703625_0014.
- Director's Referral/Voluntary Plan of Correction issued February 20, 2018, in inspection report #2018_509617_0004.
- CO #004 issued January 10, 2018, in inspection report #2017_624196_0016. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2020(A1)

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

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

The licensee must be compliant with s. 8 (1) (b) of Ontario Regulation (O. Reg.) 79/10.

Specifically, the licensee must:
A) Provide and maintain records of training to all Health Care Aides (HCAs) related to the identification of new or worsening issues of altered skin integrity,
including the requirement to observe residents' skin condition on each shift, and
to document, as well as verbally report any identified skin issues.

B) Provide and maintain records of training to all registered nursing staff on the
immediate assessment and treatment, as required, of new or worsening issues
of altered skin integrity.

C) Develop, implement, and document a weekly auditing system to ensure that
new and worsening issues of altered skin integrity are promptly assessed by registered nursing staff and treated as required.

D) Develop, implement, and document an auditing system to ensure that residents with identified changes and issues that present nutritional implications, are promptly assessed by a Registered Dietitian, and action is taken when clinically indicated.

Grounds / Motifs :

1. The licensee has failed to ensure that where the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any policy, the licensee ensured that the policy was complied with.

In accordance with O. Reg. 79/10, s. 48 (1) 2., the licensee was required to ensure that 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 was implemented in the home. In reference to O. Reg. 79/10, s. 50 (2) (b) (i), the program was required to ensure that a resident exhibiting altered

skin integrity, including skin breakdown, pressure ulcers, skin tears, or wounds received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

In accordance with the Long-Term Care Homes Act (LTCHA), 2007, s. 11 (1) (a), the licensee was required to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. Pursuant to O. Reg. 79/10, s. 68 (2) (a), the program was required to ensure the programs included the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration. In reference to O. Reg. 79/10, s. 68 (2) (b), the programs were required to include the identification of any risks related to nutrition care and dietary services and hydration.

Specifically, staff did not comply with the home's policies titled "Skin and Wound Program: Prevention of Skin Breakdown - RC-23-01-01" and "Skin and Wound Program: Wound Care Management - RC-23-01-02".

The home's policy "Skin and Wound Program: Prevention of Skin Breakdown - RC-23-01-01", last updated December 2019, stated that care staff were to, daily on all shifts, "observe residents' head to toe skin condition, including heels, elbows, back of head and other pressure points, during the provision of personal care", "document altered skin integrity in Daily Care Record or electronic equivalent", and "promptly report verbally any changes … to the nurse". The policy stated that nursing staff were to then "promptly assess/address all skin concerns reported by the care staff". Once skin issues were identified, the policy indicated that the nursing staff were to conduct a head to toe assessment and implement a comprehensive plan of care including interventions to address risk factors associated with skin breakdown.

The home's policy "Skin and Wound Program: Wound Care Management - RC-23-01 -02", last updated December 2019, stated that care staff were to "promptly report changes in skin integrity observed during daily care and weekly bath/shower to the Nurse for immediate assessment" and "document altered skin integrity as per home's process. In homes with Point of Care (POC) tablets, the care staff will document by exception once a shift". The policy stated that nursing staff were to "promptly assess all residents exhibiting altered skin integrity on initial discovery", and "generate

individualized resident plans of care" and use these to "implement preventative measures, treat healable and non-healable wounds, or for management of palliative wounds".

The home's policy "Nutritional Assessments - NC-04-01-03", last updated March 2020, stated that the Registered Dietitian (RD) was to complete a nutritional assessment on every resident whenever a significant change in the resident's health condition had nutritional implications. The policy indicated that upon referral or worsening condition, the appropriate assessment in the appendix should be completed, as needed.

a) A complaint was received by the Director related to the provision of skin and wound care to resident #002.

A review of resident #002's electronic POC records for March 2020, noted that a new skin issue had been identified for resident #002 by an HCA on a specified date in March 2020. The new skin issue was classified as an early stage of altered skin integrity. Four days later, the POC documentation identified that an additional skin change was noted, indicating that the area had further deteriorated, and that multiple wounds were present.

Inspector #757 conducted a review of resident #002's electronic health records. An assessment titled "Skin - Impaired Skin Integrity Assessment" was conducted by the home on the same day that the area of altered skin integrity was noted to have deteriorated. The assessment identified the presence of multiple wounds, and indicated that they had been cleansed, a treatment applied, and that referrals were made to the Registered Dietitian (RD) and Nurse Practitioner (NP).

No skin/wound assessments or progress notes related to the resident's impaired skin integrity could be identified on the specified date in March 2020, when the initial change in skin condition had been documented.

A clinical note from a later specified date in March 2020, written by NP #109, indicated that the resident's wound had progressed significantly. An electronic wound note from the same date, indicated that the wound size had increased, and indicated that the type of tissue in the wound had deteriorated. Progress notes indicated that the resident was also being treated for other wounds which had developed. A

progress note from a specified date in April 2020, written by NP #109, identified that resident #002 had multiple risk factors that predisposed them to non-healing wounds.

During an interview conducted with HCA #103, they stated that they were the first staff member to note the change in the resident's skin condition, noting that it was a small area at the time. The HCA indicated that when HCAs noted these skin changes, in addition to documenting the change electronically in POC, they would provide a verbal report to the Registered Nurse (RN), Registered Practical Nurse (RPN), or Unit Coordinator. The HCA indicated that they had provided a verbal report regarding the change in resident #002's skin integrity. The HCA further indicated that when a change in skin condition was noted in POC, an electronic alert was automatically generated for the nursing staff to follow up.

The home's Wound Care Lead confirmed that when the HCA staff documented a change in skin condition in the electronic POC system, an alert would have been created, and one of the home's nursing staff would have seen the notification.

The Inspector conducted an interview with the home's Administrator. They stated that there should have been a skin assessment for resident #002 after the new skin issue was initially identified in March 2020. The Administrator stated that the staff did not follow the home's policy to "promptly assess/address all skin concerns reported by the care staff", and indicated that the delay in assessment and subsequent treatment could have contributed to the initial development of the resident's wounds.

b) A complaint was received by the Director related to the provision of dietary services to resident #002.

During an interview with HCA #103, they stated that in January 2020, they had reported to an RN, RPN, and RD #106 that they had observed resident #002 demonstrating a specified behaviour that indicated a risk for certain dietary issues.

Inspector #757 conducted a review of resident #002's electronic progress notes. A progress note from March 2020, written by RN #108, noted that the resident had again been noted to be demonstrating the specified dietary behaviour, and indicated that a referral to RD #106 was made as a result. A progress note from the following day, written by RD #106, indicated that they were following up regarding the resident's behaviour, but that a specified assessment had not been completed,

noting that it was not completed as the resident had an illness at the time. The note also stated that the resident was to be provided with specified textures for food and fluids.

Progress notes from April 2020, indicated that the resident had continued to be observed demonstrating the specified dietary behaviour, and was also demonstrating additional dietary concerns which further indicated dietary risks.

The specified assessment which had not been completed previously, was conducted by RD #106 in April 2020, approximately one month after the assessment was initially to be conducted. The assessment identified that the resident was experiencing additional dietary concerns. A progress note related to the assessment indicated that the resident required a significant change to their dietary care as a result of the assessment.

During an interview conducted with RD #106, they stated that residents who demonstrated the same specified dietary behaviour as resident #002 were at risk for certain dietary issues. The RD noted that when these behaviours presented in a resident, they would want to assess the resident and make any changes required to their care. The RD indicated that at the time the specified assessment the resident was initially referred for in March 2020, the home was encouraging staff to limit non-essential resident interactions. They also indicated that this type of assessment should have been completed as soon as the issues were identified, and that it was an essential assessment. The RD further stated that a resident who had dietary issues similar to resident #002's was at risk for multiple significant complications. The RD stated that the ordering of a specified diet texture in March 2020 could have posed a risk for the resident experiencing certain complications, and that if they had completed their assessment at that time, and noted the issues, they would have changed the order. They stated "I would say definitely it was a possibility that [the dietary order and the delayed assessment] could have contributed to [the resident's] decline. That's an area we could have done better".

Inspector #757 conducted an interview with the home's Administrator, where they indicated that RD #106 could have donned personal protective equipment and completed the specified assessment in March 2020, despite the resident's illness at the time. The Administrator stated that the home's policy to complete a nutritional assessment, including the specified assessment, whenever a significant change in a

resident's health condition which had nutritional implications presented, was not followed.

c) Inspector #757 conducted a review of resident #004's electronic health records. The Inspector noted two assessments from a specified date in February 2020, which were titled "Skin - Wound Assessment - PUSH". Both assessments stated that they were the "initial" assessment, indicating "new wound, no previous assessment". The assessment for one wound indicated that the wound had been acquired in the home, and was classified as a specified type of wound. The assessment for another wound indicated that the wound had been acquired in the home, and was classified as the same type of wound. Both assessments indicated that the wounds were a moderate size and that the tissue type in the wound beds indicated a significant alteration of the resident's skin integrity. The record review did not locate any assessments or progress notes related to the identification or assessment of these wounds prior to the specified date in February 2020.

The Inspector reviewed the home's electronic POC Records for the period of January 1, 2020, to the specified date of assessment in February 2020, related to the provision of care of resident #004. Under the heading of "MONITOR - Skin Observation", the POC system prompted the HCAs each shift to answer the question "Does the Resident have a NEW skin issue?", and provide the classification of skin observation if a new skin issue was identified. All entries over the identified time period indicated that there had been no new skin issues identified for the resident.

During an interview with the home's Wound Care Lead, they indicated that new skin and wound issues were expected to be identified by HCAs in the electronic POC system. The Wound Care Lead stated that baths were provided to residents twice weekly by HCAs, that skin condition should have been assessed at that time, and any significant changes reported to the registered staff in order to prompt an assessment. They stated that they "really rely on HCAs to let us know when there are skin issues". The Wound Care Lead indicated that by the time resident #004's wounds had reached the size that they were on the specified date in February 2020 when the wounds were initially assessed, with the tissue type indicating a significant alteration in skin integrity, that they would have presented for some time before being identified. They added that the HCA staff should have identified this issue and brought it to the attention of the registered nursing staff much earlier.

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

During an interview with the home's Administrator they stated that by the time resident #004's wounds had progressed to the state that they were assessed at on the specified date in February 2020, that they would have been present for some time, and should have been identified prior. The Administrator indicated that staff did not follow the home's Skin and Wound Program policies, and that the issue should have been brought to the attention of nursing staff earlier, stating "You don’t just show up at [significantly altered skin integrity], so somewhere along the line someone did not follow up and alert".

The decision to issue a CO was based on the severity of the issue, which was a level 3, indicating actual harm to residents. The scope of the issue was a level 2, indicating the issue was a pattern. The home's compliance history for the issue was a level 3, indicating previous non-compliance to the same subsection:
- CO #001 issued August 17, 2018 in inspection report #2018_703625_0014.
- WN issued January 4, 2019 in inspection report #2018_783742_0001. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Nov 30, 2020(A1)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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:

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

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

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

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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 14th day of October, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DAVID SCHAEFER (757) - (A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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