Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2019	2019_751649_0007 (A2)	017637-17, 021191-17, 024831-17, 027623-17, 002255-18, 004566-18, 005264-18, 011942-18, 028106-18, 028521-18, 032377-18, 032514-18, 004329-19	Complaint

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street TORONTO ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street NORTH YORK ON M6A 2E1

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

Amended by JOY IERACI (665) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

Compliance Due Date was changed to September 30, 2019.

Issued on this 16th day of July, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 16, 2019	2019_751649_0007 (A2)	017637-17, 021191-17, 024831-17, 027623-17, 002255-18, 004566-18, 005264-18, 011942-18, 028106-18, 028521-18, 032377-18, 032514-18, 004329-19	Complaint

Licensee/Titulaire de permis

The Jewish Home for the Aged
3560 Bathurst Street TORONTO ON M6A 2E1

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

The Jewish Home for the Aged
3560 Bathurst Street NORTH YORK ON M6A 2E1

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

Amended by JOY IERACI (665) - (A2)

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): March 8, 12, 13, 15, 18, 19, 20, 21, 22, 25, 26, 27, 28, 29, April 1, 2, 3, 4, 5, 8 (off-site), 9, 10, 11, 12, 15, off-site on April 17, 23, 24, 25, 2019.

Log #017637-17 related to safe and secure home and reporting; log #024831-17 related to skin and wound care, Residents' drug regimes, and plan of care; log #021191-17/ CIS #2824-000034-17 related to a missing resident; log #027623-17 related to medication management system, plan of care, and skin and wound care; log #002255-18 related to infection prevention and control program issue, safe storage of drugs, additional training — direct care staff, nursing and personal support services, prevention of abuse and neglect, Residents' Bill of Rights, responsive behaviours, bathing; log #004566-18 related to prevention of abuse and neglect and medication management system; log #005264-18 related to prevention of abuse and neglect; log #011942-18 related to continence care and bowel management, plan of care, prevention of abuse and neglect, oral care; log #028106-18 related to plan of care, communication and response system, continence care and bowel management, prevention of abuse and neglect, transferring and positioning technique, maintenance services, falls prevention and management, pest control; log #028521-18 related to plan of care, Infection prevention and control program; log #032377-18 related to transferring and positioning technique, log #032514-18/ CIS #2824-000056-18 related to duty to protect; and log # 004329-19 related to plan of care.

A Voluntary Plan of Correction (VPC) related to O. Reg. 79/10 s. 36 was identified in this Complaint Inspection which was conducted concurrently with inspection #2019_751649_0005 (Complaint Inspection Logs #000722-19 and #001094-19), dated May 14, 2019, and issued in that report.

During the course of the inspection, the inspector(s) spoke with the inspectors

spoke with director of resident care and experience (DRCE), managers long term care (MLTCs), director of clinical support services (DCSS), director redevelopment & facilities (DRF) registered dietitian (RD), facility manager (FM), environmental manager (EM), clinical educator (CE), manager security, telecommunications & emergency preparedness (MSTEP), interim food service manager (I-FSM), physiotherapist (PT), occupational therapist (OT), registered nurses (RNs), resource nurse, social worker (SW), behavior support ontario lead (BSOL), registered practical nurses (RPNs), infection control practitioners (ICPs), maintenance supervisor (MS), coordinator security & telecommunications (CST), administrative secretary, personal support workers (PSWs), recreationists, private care companion, residents and/or substitute decision-makers (SDMs), and family members.

During the course of the inspection the inspectors observed staff to resident interactions, the provision of care, observed meal services, reviewed residents' health records, staff training records, security footage, investigation notes, water temperature logs, and any relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Critical Incident Response
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of the original inspection, Non-Compliances were issued.
- **21 WN(s)**
- **13 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure residents were bathed twice weekly by the method of his or her choice, including tub baths, showers and full body sponge bath, unless contraindicated by a medical condition.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint

related to resident #001 not receiving a shower by their method of choice.

Record review of the PSWs activities of daily living (ADL) work form indicated that resident #001 received showers at least twice weekly. During multiple interviews with PSWs working on all units in the home, it was revealed that the practice of providing a shower to residents in their private washroom was prevalent in the home. The inspector observed that inside each resident's private washroom, located beside the toilet, was a short black hose connected to a shower controlled device.

During an interview, PSW #131 verified that they showered resident #001 exclusively in their private washroom. The PSW als stated the following:
-The method used to shower residents in their private washrooms.
-This method of showering the residents was not really sanitary.
-Some PSWs actually bring in their own rain boots for giving those showers in the resident's private washrooms.
-It was really not very pleasant, but we have to give the showers that way.
-We complained about it but nobody listened, that is the system used here.

During an interview, resident #001's SDM #178 informed the inspector that they have asked staff numerous times to stop showering the resident and to use the designated shower room; however, they continued to shower the resident in their private washroom.

During an interview, registered staff RPN #187 stated that PSWs gave the residents perineal care using that small hose in the shower area in the resident's private washroom. The RPN stated that they believed PSWs were also providing showers for residents in those washrooms as well; however, they believe the intent of that hose and water in the private washroom was to provide residents with perineal care after using the toilet. The RPN also stated that it was not a dignified or a clean way to shower residents; and also stated that the home have two designated shower/tub rooms on each unit and those should be used to bathe residents.

During separate interviews with managers long term care (MLTCs) #116, #145, #149, they each acknowledged being aware that residents were showered in the resident's private washrooms.

MLTC #116 stated that the area in the washroom was not meant to be used as a

shower; it was meant for cleaning the resident during peri-care. However, sometimes it was easier for staff to just wash the resident aside from the showers they receive twice weekly. And, MLTC #116 believed it should be the resident's preference, and that people should have their choice.

MLTC #145 stated that the expectation was that if the resident's family does not want the resident to be showered in their private washroom, the staff should be using the shower/tub room to bathe the residents.

The DCSS #142 stated the following during the interview:
-We were made aware that residents were being showered in their private washrooms.
-This has been an ongoing issue for many years.
-There were communal shower/tub rooms available for use; however, the direct care staff currently under-utilized those rooms; or as far as we were made aware, in some cases, they were never utilized for the purpose for which they were built, they were used for storage of equipment.
-As long as that little hose remain within those private washrooms; the staff will continue to use that area to shower residents.
-We are against the rule of using the convenience related to showering residents in their private washroom.
-Infection Prevention and Control (IPAC) and Facilities were against the use of those private washrooms to shower residents since that area was not meant to be used in that way.
-This remains a big issue for facilities to manage because when residents were showered in the private washroom, the water seep through the tiles and affects the flooring in the hallways, which results in bubbling underneath the floors with a huge cost for repairs.

The director redevelopment & facilities DRF #143 stated the following during the interview:
-We were aware that residents were being showered in their private washrooms.
-The home underwent a retrofitting process to install bathtubs in one of the two shower rooms which were located on each unit; therefore, the second shower room was always available for use to provide residents' with a shower on each unit.
-Once the tubs were installed, facilities invited the vendor to the home to provide training for all direct care staff in the home; and all communal shower rooms in the home were reopened and ready for use.

-We informed direct care staff to return to using the designated shower rooms on each unit since we did not think residents should be showered in their private washrooms - that area was not meant to be used as a shower room for residents.
-Showering resident in the private washrooms causes issues in the facility.
-We rectified the issues with the shower/tub rooms so that showering residents in the private washrooms would not be occurring any more.

Therefore, the home failed to ensure residents were bathed twice weekly by the method of his or her choice, including tub baths, showers and full body sponge bath, unless contraindicated by a medical condition. [s. 33. (1)]

2. Resident #007 was included in order to expand the sample.

Record review of the PSWs ADL work form indicated that resident #007 received showers at least twice weekly.

During multiple interviews with PSWs working on all units in the home, it was verified that the practice of giving a shower to residents was to shower the resident in their private washroom. The inspector observed that inside each resident's private washroom, beside the toilet, there was a short black hose connected to a shower controlled device.

During an interview, resident #007's SDM #177 was visibly upset when they informed the inspector that they have asked the staff numerous times to stop showering the resident in their private washroom; and they still continued.

During an interview, registered staff RPN #135 verified that PSWs provided showers in the resident private washrooms because sometimes residents complain of feeling cold when they were transferred down the hallway to the designated shower/tub rooms. In addition, the RPN stated that they were not aware of the family's request to shower the resident in the shower room instead of the washroom; and that going forward resident #007 will be provided their shower in the designated shower/tub room. Therefore, the home failed to ensure resident #007 received a shower by the method of their choice. [s. 33. (1)]

3. Resident #019 was included to expand the sample.

On April 10, 2019, at 1030 hours, Inspector #502 observed resident #019 being provided a shower in the resident's private washroom. PSWs #159 and #160

washed the resident with soap and water, dried the resident, however, the peri-care was not provided during the shower.

During an interview, PSW #160 stated that they were not able to provide peri-care for the resident during the shower. However, peri-care would be provided once the resident was transferred back to bed. The PSW also stated that if a resident was able to walk to the shower room independently or if they requested to be showered in the designated shower room, they would be brought to that room and provided a shower. [s. 33. (1)]

4. Resident #020 was included to expand the sample.

On April 10, 2019, at 1030 hours, Inspector #502 observed resident #020 being provided a shower in the resident's private washroom. The resident was showered by PSWs #159 and #160, with the support of the resident's private companion. The PSWs washed the resident with soap and water, dried the resident; however the resident was not provided peri-care during the shower.

During an interview, PSW #160 stated that they were not able to provide peri-care for the resident during the shower. However, peri-care would be provided once the resident was transferred back to bed. [s. 33. (1)]

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 001

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.

A complaint was submitted to the MOHLTC alleging that a new PSW had been abusing resident #004.

Resident #004 was not interviewable.

Record review and staff interview indicated that when resident #004 told PSW #117 during care that they were rough, the PSW responded to the resident that they were not rough and referred to the resident's size.

During an interview with PSW #117, they acknowledged what they had told the resident and explained to the inspector that they had used the wrong word and did not intend to hurt the resident's feelings.

In an interview with MLTC #145, they explained that staff were supposed to be professional and validate the resident's concern and ask if they were okay.

PSW #117's interaction with resident #004 on the above mentioned date, indicated that the resident had not been treated with dignity and respect during care. [s. 3. (1) 1.]

2. The MOHLTC received a complaint related to resident #001's dignity and privacy.

Record review indicated that another resident #002 who resided on the same unit, exhibited an identified responsive behaviour.

During separate interviews, PSWs #132 and #185 verified that although resident #002 was now in a mobility device related to another diagnosis, the resident used to have an identified responsive behaviour. PSW #185 further stated that resident #001's SDM was constantly complaining about resident #002's responsive behaviour because resident #001 would have an identified reaction. The PSW also verified that these actions by resident #002 could infringed on resident #001's dignity and privacy.

During an interview, registered staff RPN #161 verified that resident #002 had an identified responsive behaviour and many interventions were tried without success. PSW #172 and RPN #161 both stated that it was challenging providing care for the number of residents who resided on the unit, and at the same time closely monitor residents who had the identified behaviour on the unit. Both staff also verified that behavior strategies were put in place but they often did not stop the resident's behaviour.

Therefore, the home failed to ensure resident #001 was fully respected and treated in a way that fully recognized their individuality and respected their dignity. [s. 3. (1) 1.]

3. The licensee has failed to ensure that every resident has the right to, have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

On April 1, 2019, at approximately 0950 hours the inspector observed the electronic-medication administration record (e-MAR) screen open displaying a resident's personal health information.

RPN #126 was observed at another computer inside the nursing station on an identified unit. When the RPN came over to the medication cart the inspector inquired if they were giving medications and they confirmed they were.

During a follow up interview with RPN #126, they acknowledged that the e-MAR screen should have been locked and explained to the inspector there was a function to do so for privacy and confidentiality.

In an interview with MLTC #145, they acknowledged that the e-MAR screen should have been closed when not in use. [s. 3. (1) 11. iv.]

4. On March 8, 2019, at approximately 1050 hours the inspector observed the e-MAR screen on the medication cart open on an identified unit, while the RPN was inside of a resident's room. No residents were observed in the area at this time.

In interviews with RPN #101 and MLTC #106, they both acknowledged that the e-MAR screen should be closed to protect the residents' personal health information. The DRCE was advised of this area of non-compliance. [s. 3. (1) 11. iv.]

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 every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and every resident has the right to, have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was a safe and secure environment for its residents.

The MOHLTC received a CIS reporting a resident missing from the home.

The CIS report stated that on an identified date, resident #013 left the building without notifying staff. During the end of the night shift check, the PSW reported that the resident was not in their room. Staff were concerned as the resident had no history of leaving early in the morning. The resident was later found. The CIS reported that resident #013 was able to go out alone.

Interview with PSW #168 indicated that they were assigned to the resident during the night shift on an identified date. PSW #168 reported that it was a busy night and they attended to other residents on the unit. PSW #168 reported that they did rounds and stood at the door and heard the resident breathing but did not visually see the resident in their room. PSW #168 reported that they did not visually see the resident during the night, and could not recall when was the last time they had

seen the resident. PSW #168 reported that resident #013 was usually awake around an identified time and in their washroom. PSW #168 reported that on that night shift they noticed that the resident's washroom light was off at an identified time and they had not gone in to check on the resident. PSW #168 reported that it was during the change of shift at an identified time they were informed by PSW #117 that the resident was not in their room and a search for the resident was started. PSW #168 reported that although the resident was able to leave the unit on their own, they had never left the unit during the night.

Interview with PSW #166 indicated that they were assigned as the float PSW on an identified date. PSW #166 reported that the unit was busy that night, and the resident had always requested not to be disturb overnight, however the staff would still go to the door to check on the resident. PSW #166 stated that they did not recall if they checked the resident that night, and reported that they were informed by PSW #117 in the morning that the resident was not in their room. PSW #166 also reported that the resident did not leave the unit during the night.

Interview with MSTEP #169 indicated that security staff were dispatched to assist with the search of the missing resident and a review of the security footage was conducted. The security footage revealed that the resident exited the building through Apotex entrance doors. It was revealed on the security footage that the sliding doors had been forced open by a Toronto EMS crew hours when the ambulance crew were transporting another resident to the hospital. As the sliding doors were left open, the resident was able to walk out the doors. The inspector reviewed the security operations incident report that captured a picture of resident #013 exiting the building. Resident #013 was seen walking through the open sliding doors freely without pressing a key code and had not followed anyone else out the door.

A review of the home's investigation notes indicated that several people saw the sliding door open during the night and did not report it. The inspector inquired with the MSTEP #169 when the security rounds were conducted during the night shift, as the home's investigation noted that the security hourly rounds required improvement.

Given the evidence that the Apotex entrance doors were left open and resident #013 exited, the evidence that the home's investigation found that several people saw the sliding doors open during the night and did not report it, and the evidence that the home's investigation found that the security rounds required

improvement, the inspector concluded that the home did not ensure a safe and secure environment for resident #013. [s. 5.]

2. The MOHLTC received a complaint related to resident #021 reported being missing.

Record review of the Meditech electronic documentation system indicated:
-On an identified date, resident #021 was assessed as orientated to their environment only by knowing the location of their own room, and occasionally needed direction from areas on their own unit; and the resident used a mobility aide.
-On a later date the resident was assessed as having an identified responsive behaviour, and was at risk of getting lost if they left the building.

Record review of the Meditech progress notes indicated at an identified time, resident #021 was seen ambulating in the unit hallway close to their room. At a later time, PSW #180 who was assigned to the resident could not locate the resident to provide care, and notified registered staff RPN #182. Following the notification all three staff assigned to the unit commenced a search of the unit which was thought to be inclusive of all rooms without success. Registered staff RPN #182 alerted Resource Nurse RN #181 who was the evening shift building supervisor. During an interview, RN #181 stated that they attended the unit; verified with the registered staff that all rooms were searched; then requested that all staff working on the other two units on the floor conduct a search in an attempt to locate the resident.

Record review indicated a couple hours later the resident was not located after searching all areas on the floor; therefore, the home's security team was alerted as per the Emergency Code Yellow (missing resident) policy. The progress notes indicated that shortly after security was notified the resident's family was notified, and they arrived on the unit, soon after the police arrived.

During the course of the Code Yellow search for the missing resident, registered staff RPN #182 documented in the progress notes that all staff and security continued to search all residents' home units, and the external areas of the building including the parking lot and surrounding streets near the facility. The documentation indicated that a code yellow stage II was called at an identified time by the MSTEP #169.

Record review of the security Emergency Code Yellow documentation indicated that the Toronto Police Service officers arrived on site and suggested re-searching the resident's home unit. Shortly after the search began, the resident was located on their home unit in an identified location. The resident was immediately assessed and found to have no negative effects or injury; and the code yellow was cancelled.

During separate interviews, registered staff RN #181 and RPN #182 verified the information as documented above. RPN #182 also verified that they attempted look in an identified location during the initial search, however, they could not access the location to search. PSW #180 also stated during the home's investigative interview that they were unaware of the how to access the location; and therefore, did not conduct a search of that location.

During the interview, RPN #182 explained that a few weeks after the incident occurred, they observed a resident who also resided on the unit and had an identified responsive behaviour, led another co-resident to similar location. The RPN reflected back on this incident, and thought that could be one possible explanation as to how resident #021 might have gotten inside the location.

During an interview, RN #181 verified that they did not search the location where the resident was found when they arrived the unit; and accepted full responsibility for the oversight as the supervisor of the building. RN #181 stated that they accepted the staff word when they reported that all rooms on the unit were previous searched, instead of conducting their own search of all rooms when they arrived on the unit. The RN was not sure if security had conducted their own searched of the location when they arrived on the unit.

During an interview, MLTC #116 stated they were not working in the home at the time of the incident. However, they verified that the expectation was that staff who worked on the residents' home units conducted a full search of all rooms located on the affected unit during the Emergency Code Yellow (missing resident) Response. Therefore, the home failed to ensure that the home was a safe and secure environment for resident #021. [s. 5.]

3. On March 18, 2019, resident #009 was found walking in the hallway outside their locked unit. The resident was brought to the inspectors' office area by a visiting family member. The resident was then taken back to the unit by the activities staff.

The resident required the use of an identified device as they exhibited identified responsive behaviour. The inspector observed the resident did not have the identified device in place on the above mentioned date.

Interview with RPN #107 confirmed that resident #009 exhibited identified responsive behaviours and required the use of an identified device. RPN #107 reported that the resident currently did not have the identified device in place and has not used the identified device for some time as the resident was able to take the device off. RPN #107 reported that the resident had exited and was found out of the unit on multiple occasions. RPN #107 also identified resident #015 and resident #016 who also required the use of an identified device but did not currently have the device in place.

The resident currently resided on a locked unit. A review of the progress notes indicated multiple dates where resident #009 was found off the unit, and was able to leave the unit as the mag lock doors to the locked unit were not functional. There were several dates below that resident #009 was found off the unit.

-Resident #009 was found off the unit as they followed behind a family member and the mag lock doors were not working.

-Resident #009 was found by the evening PSW at a street entrance, was found not wearing their identified device and the exit door was not working properly. A request was made for facilities to come and fix the door but no one came to fix the door.

-Resident #009 was found outside of the unit, the exit door was not working and the identified device was not working. A request was made for facilities to come and fix the door but no one came.

-Resident #009 was found outside the unit, the exit door was not locked.

-Resident #009 was found outside the unit multiple times, the exit door and stairs were not working. A request was made for facilities to come and fix the door but no one came to fix the door. The nurse had identify that this was a safety issue as there were residents with identified responsive behaviours on the unit.

-Resident #009 was found outside the unit, the exit door was not working.

Progress notes review for resident #015 indicated on an identified date the resident was also found outside of unit as the exit door was not working and the resident did not have an identified device in place.

The home was unable to retrieve the maintenance reports for the five identified dates where the mag doors were not working. A review of the maintenance log for an identified date indicated that the request to fix the doors were placed for many days before it was fixed by the facilities technician.

The inspector inquired what alternatives methods have been approached as the resident does not want the identified device in place, and RPN #107 indicated that no alternative methods were reviewed.

When asked how the staff ensure that resident #009 was kept safe and secure when their identified device was not in place, RPN #107 and PSW #176 reported that they tried to observe the resident while they are performing their duties, however both the RPN and the PSW confirmed that there were times that resident #009 had left the unit as the mag door lock was not functional and their identified device was not in place.

Given the fact that no alternative methods have been discussed related to the use of the identified device, multiple identified dates where the mag door locks were not working and the resident was able to exit the unit, and that resident #009 currently does not have a identified device in place, the inspector concluded that the home did not ensure a safe and secure environment for resident #009. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker were given an opportunity to participate fully in the development and implementation of the resident's plan of care.

A complaint was submitted to the MOHLTC alleging that a new PSW had been abusing resident #004.

Resident #004 was not interviewable.

Record review indicated that PSW #117 had worked with the resident on the evening shift of an identified date. According to the RPN's documentation the resident reported that PSW #117 had been rough with them during care and that the PSW had referred to the resident's size. The RPN's documentation stated that the resident reported that they could not sleep because they were upset with the PSW. The RPN told the inspector they had informed the RN of the allegation.

No action was taken by the home when the resident reported on an identified date that PSW #117 had been rough during care. According to the home's staff schedule and PSW #117's documentation they worked with the resident the following day after the resident had reported they had been rough with them.

According to the home's investigation notes the resident's family member sent a written e-mail, to the home expressing concern about the care that was provided by PSW #117 to resident #004 on an identified date. The home's MLTC at the time met with PSW #117 and identified that abuse was not substantiated. PSW #117 continued to work with resident #004 on another date.

On a later date according to the resident's progress notes, their family member who was visiting the resident reported that the resident had a reaction because the same PSW they were not happy with had walked into the resident's room.

A review of the home's investigation notes indicated there was communication from the MLTC at the time to the administrator that PSW #117 will continue to work with resident #004, in twos when providing care.

According to the home's investigation notes, an e-mail was sent from resident #004's family member to the MLTC at the time stating that on an identified date the resident started to have a reaction after the same PSW had left the resident's room.

Based on the information above, resident #004's family member who is also their SDM were not given an opportunity to participate fully in the development and

implementation of the resident's plan of care.

During an interview with MLTC #145 they explained that the home always have to collaborate and notify family members on the outcome of the investigation. [s. 6. (5)]

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

A complaint was received by the MOHLTC alleging that resident #004 had received an identified item on their lunch tray that they were not allowed to have and that this was the fourth occurrence.

Record review indicated that on identified dates the resident had been assessed by the speech-language pathologist (SLP) and ordered a diet restriction.

A review of the resident #004's care plan at the time of the inspection, in PCC did not indicate this restriction.

According to the meal distribution report located in the severy area indicated that the resident was on a diet restriction.

In an interview with the I-FSM #125, they indicated that the meal distribution report was part of the resident's care plan and acknowledged that the resident was on an identified diet restriction. According to the I-FSM resident #004 would have been on the same diet restriction and acknowledged that they were accidently served the incorrect diet.

In an interview with MLTC #145 they acknowledged that the meal distribution report was part of the resident care plan and stated that the dietary aide did not follow the resident's care plan when they had offered the incorrect diet on an identified date. [s. 6. (7)]

3. A complaint was received by the MOHLTC alleging that resident #004 was on an identified diet type and it was not being followed.

On March 28, 2019, an observation was conducted from approximately 1230 to 1255 hours when PSW #118 took the tray into the resident's room. A bowl of soup and a cup of juice were observed on the tray before it was taken into the

resident's room. The inspector went into the resident's room when the tray was offered to the resident by PSW #118 and observed an opened can of an identified beverage in the resident's room.

In an interview with PSW #118, they acknowledged that they were aware that the resident was on an identified diet. The PSW explained that the resident intake was monitored by checking after meals and in between how much the resident ate and drank. The PSW told the inspector they were the person who was documenting the resident's intake at meals and at the snack passes. A discrepancy was observed in what the resident ate and drank and what was documented by PSW #118.

The I-FSM #125, RD #127, and MLTC #145 were informed about the inaccurate documentation of resident #004's intake. [s. 6. (7)]

4. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

On March 18, 2019, resident #009 was found walking in the hallway outside their locked unit. The resident was brought to the inspectors' office area by a visiting family member. The resident was then taken back to the unit by the activities staff.

A review of resident's plan of care indicated that the resident required the use of an identified device as they exhibited an identified responsive behaviour. The inspector observed the resident did not have the identified device in place when they were brought to the inspectors' office.

Interview with RPN #107 indicated that a dementia observation system (DOS) was initiated on the same date after resident #009 was found outside the locked unit.

Record review of resident #009's DOS assessment tool indicated no documentation was completed on identified dates at specific times.

Interview with PSW #176 indicated that they did not document on the resident's behaviour on the identified dates as they were not informed that the resident required monitoring.

Interview with RPN #107 indicated that the home's expectation is that the PSWs

are expected to complete the DOS monitoring on every shift and confirmed that the DOS documentation was not completed on the identified dates. [s. 6. (9) 1.]

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

The MOHLTC received a complaint related to care received at the home for resident #007. The complainant reported concern that there was not enough activities for the resident and that the resident was not being asked by the staff to participate in programs.

A review of the written plan of care for resident #007 indicated that the resident attends off floor programs.

Interview with recreation staff #170 and #171 indicated that activities were offered to the resident #007 in the afternoon, however the family member declined the afternoon programs. Record review and staff interview with the recreation staff also indicated due to the resident's absence from the home, the resident had not been able to attend the group program. The recreation staff indicated that they had offered 1:1 programs with the resident, however a review of the written plan of care did not identify the 1:1 program on the care plan.

Recreations staff #170 and #171 confirmed that the 1:1 intervention was not identified on the care plan, and that the written plan of care for activities was not reviewed and revised when the care needs changed. [s. 6. (10) (b)]

6. The MOHLTC received a complaint related to resident #001's identified responsive behaviors.

During the inspection, the inspector observed that the resident continued to use an identified device although they no longer had the strength or displayed the identified behavior.

During an interview the resident's SDM stated that they would prefer if the resident was offered an alternative device now that they no longer using the device for an identified behaviour; and the resident required assistance from care-givers.

During an interview, the home's BSOL #190 verified that the plan of care should have been updated to reflect the resident's current status; since they no longer using the identified device. Therefore, the home failed to ensure that resident #001 was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs has change or care set out in the plan of care was no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care, the care set out in the plan of care is provided to the resident as specified in the plan, the provision of the care set out in the plan of care is documented, the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, s.229 (8) (a) the licensee shall ensure an outbreak management system for detecting, managing, and controlling infectious disease outbreaks, including defined staff responsibilities, reporting protocols based on requirements under the Health Protection and Promotion Act, communication plans, and protocols for receiving and responding to health alerts.

A complaint was submitted to the MOHLTC alleging that resident #005 had been identified positive for an identified medical condition after a hospital transfer. According to the complainant if this medical condition had been identified sooner the resident may have been saved.

Record review indicated that resident #005 was transferred to hospital for further assessment due to an identified medical condition and was readmitted to the home on a later date. Upon readmission the resident was identified as having altered skin integrity but no swab related to an identified medical condition was not taken from this site.

The home's policy did not provide clear direction to staff which body sites to swab for the identified medical condition and staff interview indicated that the home's policy was based on Provincial Infectious Disease Advisory Committee (PIDAC) best practice and recommendations which indicated to swab an open wound site.

Further review of the home's policy on page two under re-admission directs the

staff as follows:
All clients re-admitted from Leave of Absence Medical (LOAM) must be screened for an identified medical condition within 72 hours of re-admission, providing they meet all of the following criteria:
-The client's LOAM has been greater than 72 hours
-The client's status related to the identified medical condition is unknown
-The client is being re-admitted to Apotex, Hospital (except 4E, 4W, 6W)
-The client has not been screened during previous 72 hours

A review of resident #005's clinical record in Meditech indicated that they were not screened from the altered skin integrity site for an identified medical condition when they had returned from hospital after 72 hours. According to the Dynacare lab report a swab was obtained only from the resident #005's nares and the altered skin integrity site had not been swabbed for an identified medical condition.

In an interview with RN #140 they told the inspector that since the home switched to Dynacare only one swab of the nares was being done and that Dynacare only accepted nasal swabs.

In an interview with DCSS #142, they told the inspector that swabs were collected from the nares and from open wounds. The DCSS explained that they home used to collect swabs from multiple sites but when the home switched to Dynacare, swabs were only obtained from the nares as this site has the highest yield. The DCSS acknowledged that the home's current policy did not provide a breakdown on the anatomic sites and stated it would make sense to have this information included in the home's policy.

Two other residents #021 and #022 were randomly selected. Resident #021 had altered skin integrity that was not swabbed when they had returned from hospital. Resident #022 who had altered skin integrity was swabbed when they were re-admitted from hospital.

In an interview with ICP #156, they told the inspector that screening resident #021 who had altered skin integrity would have introduced infection into the wound and with resident #022 they had physically spoken with the RPN to ensure swabs were collected from all sites.

In summary, the home's policy was not in compliance with and implemented

according to applicable requirements under the Act. [s. 8. (1)]

2. In accordance with O. Reg. 79/10, s. 114 (2) the licensee shall ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the home's policy titled 6.2: Narcotic and controlled medications, revised May 2, 2016 and February 22, 2017, directs the nurse as follows:
-The nurse on duty responsible for medication administration shall be responsible for possession of the narcotic and controlled medication storage box key.

While conducting an observation related to resident #004 on March 20, 2019, at approximately 1220 hours the inspector observed a nursing student on a home area opening and closing the medication cart several times with keys in their possession.

In an interview with RPN #126, they acknowledged that the nursing student had the narcotic key as all the keys were on the same bunch. When the RPN was asked if the nursing student was allowed to have the narcotic key in their possession they responded that the nursing student knows their role and was not allowed to count the narcotics or go into the narcotic drawer; they stated that the student knows their limit and scope of practice.

In an interview with MLTC #145, they stated that the nursing student should not have the narcotic key in their possession. [s. 8. (1) (b)]

3. In accordance with O. Reg. 79/10, s.114 (2) the licensee shall ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

A review of the home's policy titled 3.3.1.5: Missed, Refused, Wasted Doses directs the staff as follows:
1. Missed, refused and wasted doses of regularly scheduled medications and the reasons for the same shall be accurately documented on the MAR/TAR
2. Shall immediately after a regularly scheduled dose of medication is missed; or wasted; note on the MAR/TAR the code from the chart notation legend corresponding to the reason the dose was missed or wasted in the appropriate

box on the MAR/TAR indicating the date (column), medication (row) and hour of administration (row)
3. Shall document the details of a missed, refused or wasted dose if the code for "other" is chosen from the chart notations legend in the resident progress notes.

The physician ordered two different medications for resident #017 for an identified medical condition. According to the home's pharmacy provider, these medications are not covered by the ODBP, and is to be purchased by the resident and/or family. The pharmacy attempted to communicate with the POA to receive consent but was unable to reach them. Due to the inability to communicate with the POA, the medication was not delivered and not available for the resident. During the period when the medication was not available, RPN's #164 and RPN #165 documented and signed on the MAR that they administered one of the medications over an identified period.

A review of the home's investigation file revealed that RPN #164 and #165 received a discipline letter as they repeatedly signed the MAR for a medication that was not administered. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is in compliance with and is implemented in accordance with all applicable requirements under the Act and any plan, policy, protocol, procedure, strategy or systems instituted or otherwise put in place is complied with, to be implemented voluntarily.

WN #6: 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:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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).
3. Any locks on bedrooms, washrooms, toilet or shower rooms must be designed and maintained so they can be readily released from the outside in an emergency.
4. All alarms for doors leading to the outside must be connected to a back-up power supply, unless the home is not served by a generator, in which case the staff of the home shall monitor the doors leading to the outside in accordance with the procedures set out in the home's emergency plans.O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

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 equipped with locks to restrict unsupervised access to those areas by residents, and locked when they were not being supervised by staff.

On March 11, 2019, while conducting an inspection in the home, the inspector observed that doors located on five resident care units, which lead to non-residential areas such as multiple staff offices, a staff lounge, and unsecured elevators were propped open and therefore, did not restrict unsupervised access to those areas by residents. These unit doors were not locked when they were unsupervised by the staff.

The inspector also observed that the main entrance to the Apotex Long-Term Care building was joined directly and without a physical barrier to the Baycrest Hospital; thereby, providing residents with free access to hospital site and additional exits to the outside the home.

On the second floor of the home, there were three resident care units - Redbird/ Floral Place, Elmgrove/ Ivywood, and Golden Lane/ Stoneway unit with doors propped open; and on the third floor there were two resident care units – Elmgrove/ Ivywood and Golden Lane/ Stoneway with doors propped open so that residents, staff and visitors could move freely in and out of these units. Outside the unit doors of each unit were a set of two or three elevators with direct access to all residents, staff and visitors; except for residents' who were assessed and were wearing wander guard bracelets. The home's two sets of elevators were equipped with a sensor to prevent residents wearing wander guard bracelets from leaving the unit/floor on which they reside without entry of a special code on the elevator key pad.

Record review and staff interview with registered staff RPN #182 stated an example of how a resident had left their assigned unit and wandered down to the ground floor which had direct access to the hospital and outdoors.

According to RPN #182, resident #021 had multiple incidents of leaving their unit unsupervised and boarded the elevator down to the ground floor. The ground floor has a large atrium with multiple seating areas, a coffee shop, a walkway with a gift shop, library, and a direct walk way into the Baycrest Hospital, which had its own exits to the to the surrounding streets, the parking areas and a busy main street. During each incident when resident #021 was discovered missing, direct care providers were required to search the unit, and leave the unit to search for the

resident on the ground floor. Finally, after discussion with the family and the team, the resident was transferred to a unit with the doors locked and an entry code required to exit the unit. The resident's transfer summary progress notes indicated that the "resident was ambulatory with mobility aide and had a history of an identified responsive behaviour and was not able to return to the unit on their own".

During separate interviews, MLTCs #116 and #149 acknowledged that three units on the second and two units on the third floor remains open door. Both MLTCs stated that physicians were actively involved in the care of those residents and any changes noted in cognition would be reported to the physician right away. MLTC #116 stated that if a resident was assessed to be at risk of wandering or exit seeking, they would be moved to a secure unit/floor right away. And, MLTCs #116 and #149 both verified that the doors were always left open on the second and third floors so that residents could come and go as they wish; and that during the evening the doors were closed but not locked.

During an interview, the CST #179 also acknowledged that if a resident was not wearing the wander guard bracelet and managed to exit the secure unit behind a staff or visitor, they could manage to leave the building without a barrier in place; however, staff members were usually pretty good about knowing where residents were located and keeping them in a safe space.

During an interview, the DRF #143 verified that the doors on the second and third floor units remains open; however, the entrances on the ground floor were closed and locked at 2100 hours, and re-opened at 0600 hours daily. The DRF also acknowledged that a resident who was cognitively impaired could gain access down the elevator and to the lobby by way of a new staff or a visitor; and could possibly exit the building unsupervised if they were not wearing a wander guard bracelet.

Therefore, the home has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and locked when they were not being supervised by staff. [s. 9. (1)]

2. On April 4 and 12, 2019, the inspector observed the shower/tub room door on a resident care unit propped open and the area was unsupervised by staff.

During separate interviews, registered staff RPN #184, and the home's CE #175

both acknowledged that the shower/tub room door should have been closed and locked to restrict unsupervised access to the area by residents. [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 equipped with locks to restrict unsupervised access to those areas by residents, and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy was complied with.

A complaint was submitted to the MOHLTC alleging that a new PSW had been abusing resident #004.

A review of the home's policy titled resident abuse and neglect: zero tolerance

revised on January and May 2017 directs staff if abuse of a resident is alleged, suspected, or witnessed, the member of Baycrest staff identifying the alleged, suspected or witnessed abuse will ensure the resident's immediate safety needs are met by ensuring that the alleged abuser no longer has access to the resident which require support of security. To report the suspected or witnessed abuse to the manager or Director of the unit in which the resident is receiving services.

Resident #004 was not interviewable.

A review of progress notes and staff interview indicated that resident #004 had reported to PSW #117 that they were rough during care on an identified date. The PSW reported the resident's allegation to RPN #162. The RPN spoke with the resident and documented that they had spoken with the staff and told them to ask for help when providing care. The RPN further documented that they asked the resident to give the staff a chance as they were new to the floor and if they thought they were not satisfied then they would have to report it again. RPN #162 also documented that the resident had complained that they could not sleep because they were upset with the PSW and that the RN had been notified about the incident.

Record review and staff interview indicated that the home's abuse policy had not been followed by RPN #162 on the above mentioned date, since they failed to recognize and report the resident's allegation as abuse. This failure to immediately report resulted in the same PSW continuing to work and provide care to the resident on the following shift. It was only when this incident was reported by the resident's family member to the home that an investigation was started.

During an interview with RPN #162, they told the inspector that an allegation of abuse made by a resident have to be immediately reported to the manager or on call administrator and explained that they were new at the time of the incident and had notified the RN but did not know they had to call the manager or the on call administrator.

During an interview with MLTC #145, they told the inspector that information has to be obtained from the resident and the alleged PSW removed until further investigation. If the resident information is consistent then it has to be reported to the on call manager. [s. 20. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure there was a written staffing plan that provided for a staffing mix that was consistent with residents' assessed care and safety needs, set out the organization and scheduling of staff shifts, promote continuity of care, and include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work.

The MOHLTC received a complaint related to insufficient staffing in the home.

On an identified date the inspector requested a copy of the home's written staffing plan for the nursing and personal support services program and the most recent evaluation of the staffing plan. On a later date the Administrative Secretary provided a single paged document with no heading; the names of each unit in the home; the # of beds on each unit; the registered staff complement assigned to each unit broken down by shifts (day/evening/night) and staffing categories (RN/RPN/PSW); and at the bottom of the page, the total staff per shift in each category.

The written staff plan presented did not include:
-the process or protocol used to promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident.
-a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, including 24/7 RN coverage.
-an evaluation and updated plan at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The inspector made several request for the additional information related to the written staffing plan during the inspection; however the Administrative Secretary #124 responded on behalf of the DRCE, stating that there were no additional documents available.

Therefore, the home has failed to ensure there was an inclusive and complete written staffing plan for the nursing and personal support services program available in the home. [s. 31. (3)]

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 there is a written staffing plan for the nursing and personal support services program, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures.

The MOHLTC received a complaint related to care received for resident #006. The complainant reported they came to the home on an identified date and found that the resident had comprised oral care. The complainant reported they inquired with the staff about the comprised oral care and the staff informed them that they were unsure how it happened.

Review of the written plan of care indicated that resident #006 requires total assistance with hygiene and grooming.

Interview with PSW #113 indicated that on an identified date they were assigned to provide care to resident #006. The PSW reported that they assisted the resident with personal care and dressing, however they did not assist with oral care. PSW #113 stated that they were aware of the resident's comprised oral care, but unsure how it happened. PSW #113 informed the inspector that they had not provided oral care to resident #006 for months.

Interview with PSW #112 indicated that they were assigned to provide care to resident #006 in the evenings. PSW #112 indicated that they did not assist with oral care to the resident, as they were informed by the family member that while they were in the home visiting the resident, they would provide care to the resident. PSW #112 stated that they were aware of the resident's compromised oral care, but was unsure how it happened as they had not provided oral care to the resident.

Interview with resident #006's family member indicated that they had informed the evening staff that they would assist with care while in the home, but expected the staff to still provide care, including oral care, to the resident. The family member reported that they visited the resident, in the evening there was no concern with the resident's oral care, the family member did not visit the resident the next day, and returned to visit the resident the following day, they found the resident's with compromised oral care.

Review of the flow sheets for an identified period indicated that the resident received oral care twice a day. Interview with PSWs #112 and #113 indicated that although they documented that oral care was given, they did not provide this care as the family member assisted with the oral care.

Interview with MLTC #116 indicated that after the incident, both PSWs # 112 and PSW #113 received training from the home's dental hygienist on how to provide oral care to the resident. Interview with the DRCE indicated that the expectation from the PSW was to provide oral care to the resident. [s. 34. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes, mouth care in the morning and evening, including the cleaning of dentures, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise. O. Reg. 79/10, s. 73 (1).
4. Monitoring of all residents during meals. O. Reg. 79/10, s. 73 (1).
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).
7. Sufficient time for every resident to eat at his or her own pace. O. Reg. 79/10, s. 73 (1).
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

s. 73. (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. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum, monitoring of all residents during meals.

A complaint was received by the MOHLTC alleging that resident #004 had received an identified item on their lunch tray that they were not allowed to have and that this was the fourth occurrence.

Resident #004 had not been monitored during the lunch meal service on an identified date.

On March 28, 2019, an observation was conducted from approximately 1230 to 1255 hours when PSW #118 took the tray into the resident's room. A bowl of soup and a cup of juice were observed on the tray before it was taken into the resident's room. The inspector went into the resident's room when the tray was offered to the resident by PSW #118 and observed an opened can of an identified beverage in the resident's room.

In an interview with PSW #118 who served the resident the lunch tray on the above date, told the inspector that the resident does require supervision during their meals. Inspector inquired from the PSW if they had checked on the resident on the above mentioned date during their lunch meal and they responded that they had. When the inspector explained that they had been monitoring the resident from the time the tray was brought into the resident's room at 1230 hours until 1255 hours, the PSW denied they had monitored the resident during the lunch meal.

During separate interviews with MLTC #145, RD #127, and RPN #126, they all told the inspector that resident #004 required monitoring in their room during meals. [s. 73. (1)]

2. The licensee has failed to ensure that the home has a dining and snack service that includes, at a minimum providing resident #001 with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The MOHLTC received a complaint related to resident #001 not receiving assistance with feeding.

Record review indicated that resident #001 required extensive assistance with meals, one person physical assist, and constant encouragement and supervision.

During the inspection, the inspector observed the following meals:

On April 1, 2019 at 0850 hours, the table was set for resident #001; however the resident was not seated at the table during the breakfast meal. During an interview, registered staff RPN #170 informed the inspector that the resident was usually brought to breakfast at an identified time due to an identified responsive behaviour.
The inspector returned to the dining room at a later time, and observed that the resident was being fed by a PSW. The resident did not have an identified responsive behaviour.

On April 2, 2019 at 1210 hours, the inspector observed resident #001 in the dining room. The resident's full meal was placed on the table; and as the PSW walked by, they would stop to help to cut the food on the plate. At one time, the PSW stopped at the table beside the resident, and placed food into the resident's mouth, then walked away. Approximately 25 minutes later the PSW brought a stool to the table, sat down and fed the resident the lunch meal. During an interview, the PSW stated that they had to serve the meals to the other residents before they were free to sit and feed resident #001 their meal. During an interview, RPN #184 verified that the resident required assistance with feeding; and that normally the PSWs served other residents first, and then when they have the time, they would sit and feed the resident. The RPN also stated that the meal was served to the resident ahead of time so that the resident could start eating the meal, although slowly and with encouragement, and stated that the meal was still warm at the time of feeding.

On April 3, 2019 at 1205 hours, the inspector observed resident #001 seated in the dining room. The resident was served soup which was placed in front of the resident. There was no stool in place nor PSW seated at the table to provide assistance with the meal. At an identified time, the resident started to have an identified responsive behaviour and the lunch meal was served. Approximately 15 minutes later, a PSW brought a stool, sat beside the resident and fed the resident the meal.

During an interview, MLTC #149 stated that resident #001 could eat their own

meal, but that they were slow eating and may need assistance sometimes. The MLTC stated the expectation was that residents who required full assistance with meals would be assessed depending on the resident, the shift, and whether the resident was ready to eat right away or later. In addition, the MLTC stated that direct care providers usually organize the best time to feed the resident; and that the meal was served to the resident so that the resident could start eating with staff encouragement.

In summary, resident #001 required extensive, one person physical assist, and constant encouragement and supervision with meals; however, the resident was served their meals without the presence of a staff to feed the meal, or provide constant supervision and encouragement. Therefore, the home failed to ensure that resident #001 was provided appropriate personal assistance and encouragement required to safely eat and drink the meal. [s. 73. (1) 9.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home has a dining and snack service that includes, at a minimum, monitoring of all residents during meals and providing resident #001 with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents did not exceed 49 degrees Celsius, and was controlled by a device, inaccessible to residents, that regulates the temperature.

The MOHLTC received a complaint related to lack of hot water to support residents' care in the home.

Record review of the home water log in the Apotex long-term care building indicated that water temperatures were being checked during three shifts and at various residents' rooms and shower/tub rooms; and that the temperature documented were within the normal limits.

During an observation, Inspector #502 accompanied the home's MS while they recorded and documented random temperature on selected units in the home. The water temperatures recorded were noted to be significantly hot or cooler; and was outside the acceptable limits. During an interview, the MS #191 verified that something was not right with the water temperature or the thermometer being used to record the temperature; and stated that they would follow up immediately to correct the situation.

During multiple staff interviews with PSWs and registered staff, there were complaints related to frequent episodes related to lack of hot water in the pipes in the Apotex long-term care building; and staff acknowledged that they have entered numerous dates when hot water was not available on the unit, in the home's electronic maintenance care documentation system – Angus Anywhere. During an interview, PSW #131 informed the inspector that sometimes if/when hot water was not available in the home, residents showers were postponed to the next shift or next day when the hot water was available.

During an interview, the home's DRF #143, acknowledged that there was an issue with the hot water system in the home; that a pump was recently upgraded and replaced. (2) (g)]

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 procedures are developed and implemented to ensure that the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1.The licensee has failed to ensure that, drugs were stored in an area or a medication cart that was secure and locked.

On April 1, 2019, at approximately 0950 hours the inspector observed three bottles of eye drops on top of the medication cart, the medication cart was unlocked, and the fourth drawer on the cart was open.

RPN #126 was observed using the computer inside the nursing station on the unit. When the RPN came over to the medication cart the inspector inquired if they were giving medications and they confirmed they were.

During separate interviews with MLTC #145 and RPN #126, they both acknowledged that all medications should be locked inside the medication cart when the nurse is not in attendance. [s. 129. (1) (a)]

2. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was used exclusively for drugs and drug-related supplies.

While the inspector was conducting observations on March 8, 2019, at approximately 1050 hours several non-medicated items were observed in the locked narcotic drawer on an identified unit.

During separate interviews with MLTC #149 and RPN #101, they both acknowledged that the above mentioned items should not have been stored in the narcotic drawer on the medication cart. The DRCE was informed of the above items being stored in the narcotic drawer on the medication cart. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that, drugs are stored in an area or a medication cart that is secure and locked and drugs are stored in an area or a medication cart that is used exclusively for drugs and drug-related supplies, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 130. Security of drug supply
Every licensee of a long-term care home shall ensure that steps are taken to ensure the security of the drug supply, including the following:
1. All areas where drugs are stored shall be kept locked at all times, when not in use.
2. Access to these areas shall be restricted to,
i. persons who may dispense, prescribe or administer drugs in the home, and
ii. the Administrator.
3. A monthly audit shall be undertaken of the daily count sheets of controlled substances to determine if there are any discrepancies and that immediate action is taken if any discrepancies are discovered. O. Reg. 79/10, s. 130.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to ensure the security of the drug supply, including all areas where drugs were stored shall be kept locked at all times, when not in use.

On March 8, 2019, at approximately 1050 hours the inspector observed the medication cart on an identified unit, unlocked while RPN was inside of a resident's room. No residents were observed in the area at this time.

During interviews with RPN #192 and LTCM #149, they both acknowledged that the medication cart should not be left unlocked when the nurse is not in attendance. The DRCE was informed of this area of non-compliance. [s. 130. 1.]

2. On March 22, 2019, at 1020 hours, the inspector observed a treatment cart located on an identified unit to be unlocked and unsupervised. The inspector was able to open the cart and access the contents inside which include dressings, scissors, betadine solutions, and other treatment items. There were four residents located near the treatment cart who were able to access the treatment cart. RPN #107 who was assigned to the floor was not on the unit. RPN #107 returned to the unit at 1035 hours and confirmed that the treatment cart should be locked at all times when not in use. [s. 130. 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to ensure the security of the drug supply, including all areas where drugs are stored shall be kept locked at all times, when not in use, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 230. Emergency plans

Specifically failed to comply with the following:

s. 230. (4) The licensee shall ensure that the emergency plans provide for the following:
1. Dealing with,
i. fires,
ii. community disasters,
iii. violent outbursts,
iv. bomb threats,
v. medical emergencies,
vi. chemical spills,
vii. situations involving a missing resident, and
viii. loss of one or more essential services. O. Reg. 79/10, s. 230 (4).
2. Evacuation of the home, including a system in the home to account for the whereabouts of all residents in the event that it is necessary to evacuate and relocate residents and evacuate staff and others in case of an emergency. O. Reg. 79/10, s. 230 (4).
3. Resources, supplies and equipment vital for the emergency response being set aside and readily available at the home. O. Reg. 79/10, s. 230 (4).
4. Identification of the community agencies, partner facilities and resources that will be involved in responding to the emergency. O. Reg. 79/10, s. 230 (4).

Findings/Faits saillants :

1. This section applied to the emergency plans required under subsection 87 (1). O. Reg. 79/10, s. 230 (4).

The licensee has failed to ensure that the emergency plans provided for related situations involving a missing resident was not complied with.

The MOHLTC received a complaint related to a missing resident.

According to the Baycrest Code Yellow Emergency Response procedure, the first person to discover the resident missing was to inform the Most Responsible Employee, who was a manager or charge nurse. The Most Responsible Employee was to cease all non-urgent activities; direct all staff to stay in their area and search the areas; call Telecommunications and state 'Code Yellow - Stage I', and give their location; determine the level of risk; conduct a thorough search of the unit/department and stairwell; obtain a Critical Information Record online;

obtain a picture of the resident and provide to security; assist security with completing a Code Yellow alert; notify and communicate with the next of kin at their discretion; log all events with corresponding times on the Code Yellow Reporting Tool.

On an identified date and time resident #021 was seen ambulating in the unit hallway close to their room using their mobility aide. A short time after PSW #180 who was assigned to the resident could not locate the resident to provide evening care, and notified registered staff RPN #182. The RPN notified the shift Resource Nurse who requested that they complete a search of the entire unit. During the next two hours, the staff searched the Apotex Long-Term Care building, the Baycrest Hospital and surrounding areas, however the resident was not located.

Record review of security documentation notes indicated that the Toronto Police Service officers arrived on site and suggested re-searching all rooms on the resident's home unit. Shortly after the search started, the resident was located on their home unit in an identified location. The resident was immediately assessed and found to have no negative effects or injury; and the Code Yellow was cancelled.

During separate interviews, registered staff RN #181 and RPN #182 verified the information as documented above. RPN #182 also verified that they attempted to look in an identified location earlier during the initial search, however, they could not access the location to search. PSW #180 also stated during the home's investigative interview that they were unaware of the how to access the location; and therefore, did not conduct a search of that location.

During an interview, RN #181 verified that they did not search the location where the resident was found when they arrived the unit; and accepted full responsibility for the oversight as the supervisor of the building. RN #181 and RPN #182 both stated that they were not aware if security had conducted their own searched of that location when they arrived on the affected unit.

A review of the Emergency Code Yellow Incident report and post-investigation notes indicated the following:
-Telecommunications (security) was notified one hour after the resident was considered missing on the unit.
-An identified location on the resident's home unit was not searched by the staff working on the unit or the security team who attended the unit during the Code

Yellow alert.
-Search Maps were not located for all units the floor where the incident occurred.

During an interview, MLTC #116 stated they were not working in the home at the time of the incident. However, they verified that the expectation was that staff who worked on the resident's home units to conduct a search of all rooms located on the unit during a Code Yellow (missing resident) Emergency Response alert as per the home's policy. Therefore, the home failed to ensure that staff followed the Emergency Code Yellow policy since they did not open and search all rooms on the resident care unit during the search for the missing resident. [s. 230. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the emergency plans provided for related situations involving a missing resident is complied with, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home was equipped with a resident-staff communication and response system that, (a) can be easily seen, accessed and used by residents, staff and visitors at all times.

The MOHLTC received a complaint related to care received at the home for resident #007. The complainant reported concern that the call bell is often inaccessible to the resident and that the call bell was not functional.

On April 9, 2019, at 1430 hours, the inspector observed resident #007's call bell placed on top of the resident's night table that was inaccessible for the resident to use. The inspector spoke with PSW #172 who was assigned to the resident who confirmed that resident #007's call bell was inaccessible and should be accessible to the resident at all times. [s. 17. (1) (a)]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's response to interventions were documented.

A complaint was submitted to the MOHLTC alleging that a staff member had transferred resident #061 by themselves with the lift, resulting in the resident falling and sustaining injuries.

Interview with the resident's family member indicated that they had been notified by the home on an identified date that the resident had an identified responsive behaviour during care, resulting in them hitting themselves and sustaining an injury on an identified area.The family member further stated that when they visited the resident the next day they observed the first injury on an identified area. During their visit with the resident the family member identified a second injury on another identified area which they immediately brought to the home's attention.

Interview with the resident's family member indicated that they had been notified by the home on an identified date that the resident had an identified responsive behaviour during care, resulting in them sustaining an injury. The family member further stated that when they visited the resident the next day they observed the first injury. During their visit with the resident the family member identified a second injury on another site which they immediately brought to the home's attention.

A review of resident #061's progress notes indicated that PSW #111 had reported that the resident had an identified responsive behaviour during care. The progress

note also indicated that the RN was on the unit at the time and aware of the incident. According to RPN #108's documentation the resident was assessed and the injury was observed to an identified area, the registered staff tried to apply ice but the resident had refused.

A review of resident #061's clinical records did not indicate any formalized documentation of a skin assessment completed when it was reported that the resident had sustained the first injury.

During separate interviews with RPN #108 and RN #102, they both acknowledged that they should have documented a head to toe assessment for resident #061, after it was reported by PSW.

In an interview with the DRCE, in response to the question related to their expectation related to the identified injury they explained that at any time a nurse performs an assessment including a visual assessment should be documented according to the College of Nurses Standards. [s. 30. (2)]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):
1. A resident who is missing for less than three hours and who returns to the home with no injury or adverse change in condition. O. Reg. 79/10, s. 107 (3).
2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,
i. a breakdown or failure of the security system,
ii. a breakdown of major equipment or a system in the home,
iii. a loss of essential services, or
iv. flooding.
O. Reg. 79/10, s. 107 (3).
3. A missing or unaccounted for controlled substance. O. Reg. 79/10, s. 107 (3).
4. An injury in respect of which a person is taken to hospital. O. Reg. 79/10, s. 107 (3).
5. A medication incident or adverse drug reaction in respect of which a resident is taken to hospital. O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the Director was informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4).

The MOHLTC received a complaint related to resident #021 reported being missing for approximately three hours.

Record review of the Meditech progress notes indicated at an identified time, resident #021 was seen ambulating in the unit hallway close to their room. At a later time, PSW #180 who was assigned to the resident could not locate the resident to provide care, and notified registered staff RPN #182.

Record review of the security Emergency Code Yellow documentation notes indicated that the Toronto Police Service officers arrived on site and suggested re-searching the resident's home unit. Shortly afterwards, the resident was located on their home unit in an identified location. The resident was immediately assessed and found to have no negative effects or injury; and the code yellow was cancelled.

A review of the previous DRCE investigation notes indicated that the Director was not notified because the resident was missing for less than 3 hours. During an interview, the current DRCE could not locate a critical incident related to this missing resident occurrence. [s. 107. (3)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

The MOHLTC received a complaint related to the use of an identified medication for the resident.

The physician order an identified medication by mouth at bedtime for resident #006. A review of the MAR revealed that the order was transcribed on the MAR as to give the medication once daily by mouth in the morning at a prescribed time.

Interview with RPN #163 who received the new order above confirmed that the order was incorrectly transcribed on the MAR and that the resident received the medication in the morning instead of the prescribed time at bedtime.

Interview with MLTC #116 acknowledge that resident #006 did not receive the medication as prescribed. [s. 131. (2)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 136. Drug destruction and disposal

Specifically failed to comply with the following:

s. 136. (2) The drug destruction and disposal policy must also provide for the following:
1. That drugs that are to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that are available for administration to a resident, until the destruction and disposal occurs. O. Reg. 79/10, s. 136 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs that were to be destroyed and disposed of shall be stored safely and securely within the home, separate from drugs that were available for administration to a resident, until destruction and disposal occurs.

While conducting observations on March 8, 2019, of the narcotic drawer on a unit, a full blister pack of assorted medications belonging to resident #050 was observed.

A review of the home's policy #7.0 titled Destruction and Disposal of Medications and Medication related Supplies updated March 2019, indicated that medication identified for destruction by the nurses, or the consultant pharmacist during a medication system audit include any drug supply with a current order deemed to be in excess of what is needed.

In an interview with RPN #184, they explained that blister pack of medications found in the narcotic drawer belongs to resident #050 and was meant for use as a trial of self-medication. When the pharmacy delivered the medication the resident had already left the home for an identified location. According to the RPN the medication should have been returned to the pharmacy for disposal.

In an interview with MLTC #149, they acknowledged that the medications belonging to resident #001 should not have been stored in the narcotic drawer on the medication cart. The DRCE was informed of this area of non-compliance. [s. 136. (2) 1.]

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 151. Obstruction, etc.
Every person is guilty of an offence who,
(a) hinders, obstructs or interferes with or attempts to hinder, obstruct or interfere with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out the inspector's duties; 2017, c. 25, Sched. 5, s. 32 (1)
(b) destroys or alters a record or other thing that has been demanded under clause 147 (1) (c); or
(c) fails to do anything required under subsection 147 (3) or (3.1). 2017, c. 25, Sched. 5, s. 32 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members do not hinder, obstruct or interfere with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out his or her duties.

On an identified date Inspectors #189, #502, #535, and #649 exited the home during an inspection after consultation and discussions with the Toronto Service Area Office (TSAO) management team.

During an identified period the inspection team faced multiple challenges as they worked to complete the inspection. The team experienced excessive time delay related to scheduling interviews; slow response for requested documents; and inappropriate interactions with members of the team which led to a counterproductive working environment.

On a later date the inspectors returned to the home to complete the inspection following a scheduled meeting between the Service Area Office Manager at the TSAO, and the executive team at the Jewish Home for the Aged.

Therefore, the licensee failed to ensure that staff members did not hinder, obstruct or interfere with an inspector conducting an inspection, or otherwise impedes an inspector in carrying out his or her duties. [s. 151. (a)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1.The licensee has failed to ensure that a written record was created and maintained for each resident of the home.

A complaint was submitted to the MOHLTC alleging that a staff member had transferred resident #061 by themselves with the lift, resulting in the resident falling and sustaining injuries.

Interview with the resident's family member indicated that they had been notified by the home on an identified date that the resident had an identified responsive behaviour during care, resulting in them sustaining an injury. The family member further stated that when they visited the resident the next day they observed the injury. During their visit with the resident the family member identified a second injury on another site which they immediately brought to the home's attention.

A review of resident #061's progress notes indicated that resident #061 was started on an head injury routine (HIR) after an head injury was identified.

The inspector requested a copy of the HIR routine that was started on the above mentioned date for resident #003 from RPN #108 but was unable to locate in the resident's chart. Inspector observed RPN call RN #102 and requested copy of the HIR.

In an interview with RN #102, they confirmed that they were unable to locate the HIR for resident #061 that was started on the above mentioned date. The DRCE was informed that this record could not be located. [s. 231. (b)]

Issued on this 16th day of July, 2019 (A2)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by JOY IERACI (665) - (A2)
Inspection No. / No de l'inspection :	2019_751649_0007 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	017637-17, 021191-17, 024831-17, 027623-17, 002255-18, 004566-18, 005264-18, 011942-18, 028106-18, 028521-18, 032377-18, 032514-18, 004329-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 16, 2019(A2)
Licensee / Titulaire de permis :	The Jewish Home for the Aged 3560 Bathurst Street, TORONTO, ON, M6A-2E1
LTC Home / Foyer de SLD :	The Jewish Home for the Aged 3560 Bathurst Street, NORTH YORK, ON, M6A-2E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Simon Akinsulie

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

To The Jewish Home for the Aged, 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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 33 (1).

Specifically, the licensee must ensure that residents #001, #007, #019, #020 are bathed twice weekly by the method of his or her choice, including tub baths, showers and full body sponge bath, unless contraindicated by a medical condition.

Upon receipt of this compliance order the licensee shall ensure:
1. Residents #001, #007, #019, #020, and all residents and/or SDMs should be consulted to identify the residents' preferred method of bathing.

2. The resident's preferred method and location of bathing (in private washroom or designated shower/tub bath) must be clearly documented in all residents' written care plans.

3. The nursing and personal support services policy must be updated to include residents' preferred method of bathing.

Grounds / Motifs :

1. The licensee has failed to ensure residents were bathed twice weekly by the method of his or her choice, including tub baths, showers and full body sponge bath, unless contraindicated by a medical condition.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint related to resident #001 not receiving a shower by their method of choice.

Record review of the PSWs activities of daily living (ADL) work form indicated that resident #001 received showers at least twice weekly. During multiple interviews with PSWs working on all units in the home, it was revealed that the practice of providing a shower to residents in their private washroom was prevalent in the home. The inspector observed that inside each resident's private washroom, located beside the toilet, was a short black hose connected to a shower controlled device.

During an interview, PSW #131 verified that they showered resident #001 exclusively in their private washroom. The PSW als stated the following:
-The method used to shower residents in their private washrooms.
-This method of showering the residents was not really sanitary.
-Some PSWs actually bring in their own rain boots for giving those showers in the resident's private washrooms.
-It was really not very pleasant, but we have to give the showers that way.
-We complained about it but nobody listened, that is the system used here.

During an interview, resident #001's SDM #178 informed the inspector that they have asked staff numerous times to stop showering the resident and to use the designated shower room; however, they continued to shower the resident in their private washroom.

During an interview, registered staff RPN #187 stated that PSWs gave the residents perineal care using that small hose in the shower area in the resident's private washroom. The RPN stated that they believed PSWs were also providing showers for residents in those washrooms as well; however, they believe the intent of that hose and water in the private washroom was to provide residents with perineal care after using the toilet. The RPN also stated that it was not a dignified or a clean way to shower residents; and also stated that the home have two designated shower/tub rooms on each unit and those should be used to bathe residents.

During separate interviews with managers long term care (MLTCs) #116, #145, #149, they each acknowledged being aware that residents were showered in the resident's private washrooms.

MLTC #116 stated that the area in the washroom was not meant to be used as a shower; it was meant for cleaning the resident during peri-care. However, sometimes it was easier for staff to just wash the resident aside from the showers they receive twice weekly. And, MLTC #116 believed it should be the resident's preference, and that people should have their choice.

MLTC #145 stated that the expectation was that if the resident's family does not want the resident to be showered in their private washroom, the staff should be using the shower/tub room to bathe the residents.

The DCSS #142 stated the following during the interview:
-We were made aware that residents were being showered in their private washrooms.
-This has been an ongoing issue for many years.
-There were communal shower/tub rooms available for use; however, the direct care staff currently under-utilized those rooms; or as far as we were made aware, in some cases, they were never utilized for the purpose for which they were built, they were used for storage of equipment.
-As long as that little hose remain within those private washrooms; the staff will continue to use that area to shower residents.
-We are against the rule of using the convenience related to showering residents in their private washroom.
-Infection Prevention and Control (IPAC) and Facilities were against the use of those private washrooms to shower residents since that area was not meant to be used in that way.
-This remains a big issue for facilities to manage because when residents were showered in the private washroom, the water seep through the tiles and affects the flooring in the hallways, which results in bubbling underneath the floors with a huge cost for repairs.

The director redevelopment & facilities DRF #143 stated the following during the interview:
-We were aware that residents were being showered in their private washrooms.
-The home underwent a retrofitting process to install bathtubs in one of the two shower rooms which were located on each unit; therefore, the second shower room was always available for use to provide residents' with a shower on each unit.
-Once the tubs were installed, facilities invited the vendor to the home to provide

training for all direct care staff in the home; and all communal shower rooms in the home were reopened and ready for use.
-We informed direct care staff to return to using the designated shower rooms on each unit since we did not think residents should be showered in their private washrooms - that area was not meant to be used as a shower room for residents.
-Showering resident in the private washrooms causes issues in the facility.
-We rectified the issues with the shower/tub rooms so that showering residents in the private washrooms would not be occurring any more.

Therefore, the home failed to ensure residents were bathed twice weekly by the method of his or her choice, including tub baths, showers and full body sponge bath, unless contraindicated by a medical condition. (535)

2. Resident #007 was included in order to expand the sample.

Record review of the PSWs ADL work form indicated that resident #007 received showers at least twice weekly.

During multiple interviews with PSWs working on all units in the home, it was verified that the practice of giving a shower to residents was to shower the resident in their private washroom. The inspector observed that inside each resident's private washroom, beside the toilet, there was a short black hose connected to a shower controlled device.

During an interview, resident #007's SDM #177 was visibly upset when they informed the inspector that they have asked the staff numerous times to stop showering the resident in their private washroom; and they still continued.

During an interview, registered staff RPN #135 verified that PSWs provided showers in the resident private washrooms because sometimes residents complain of feeling cold when they were transferred down the hallway to the designated shower/tub rooms. In addition, the RPN stated that they were not aware of the family's request to shower the resident in the shower room instead of the washroom; and that going forward resident #007 will be provided their shower in the designated shower/tub room. Therefore, the home failed to ensure resident #007 received a shower by the method of their choice. (535)

3. Resident #019 was included to expand the sample.

On April 10, 2019, at 1030 hours, Inspector #502 observed resident #019 being provided a shower in the resident's private washroom. PSWs #159 and #160 washed the resident with soap and water, dried the resident, however, the peri-care was not provided during the shower.

During an interview, PSW #160 stated that they were not able to provide peri-care for the resident during the shower. However, peri-care would be provided once the resident was transferred back to bed. The PSW also stated that if a resident was able to walk to the shower room independently or if they requested to be showered in the designated shower room, they would be brought to that room and provided a shower. [s. 33. (1)]
(535)

4. Resident #020 was included to expand the sample.

On April 10, 2019, at 1030 hours, Inspector #502 observed resident #020 being provided a shower in the resident's private washroom. The resident was showered by PSWs #159 and #160, with the support of the resident's private companion. The PSWs washed the resident with soap and water, dried the resident; however the resident was not provided peri-care during the shower.

During an interview, PSW #160 stated that they were not able to provide peri-care for the resident during the shower. However, peri-care would be provided once the resident was transferred back to bed

The severity of this non-compliance was identified as potential for actual harm, the scope was identified as widespread. Review of the home's compliance history revealed unrelated non-compliance. Due to the scope being widespread a compliance order is warranted. (535)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2019(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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 Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 16th day of July, 2019 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by JOY IERACI (665) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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