Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 07, 2021	2020_829757_0008 (A5)	000123-20, 000793-20, 001117-20, 003017-20	Complaint

Licensee/Titulaire de permis

CVH (No. 2) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes Cambridge ON N3H 5L8

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

Birchwood Terrace
237 Lakeview Drive, R.R. #1 Kenora ON P9N 4J7

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

Amended by DAVID SCHAEFER (757) - (A5)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

This inspection report has been revised to reflect an extension of the compliance due date of compliance order #005 to allow the home to achieve sustainable compliance. The Complaint inspection, #2020_829757_0008 was completed on March 2-6 and 9-12, 2020.

A copy of the revised report is attached.

Issued on this 7 th day of January, 2021 (A5)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

Amended by DAVID SCHAEFER (757) - (A5)

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 2-6 and 9-12, 2020.

The following intakes were inspected during this Complaint inspection:

- A complaint regarding resident care concerns related to a resident fall, skin and wound care, and hygiene and grooming care; as well as concerns related to maintenance and cleanliness of the home.

- A complaint alleging resident abuse and neglect.

- A complaint regarding resident care concerns related to recreation and nutrition; as well as concerns related to staffing levels in the home.

- A complaint alleging neglect related to skin and wound care, continence care, and falls; as well as concerns related to staffing levels in the home.

This inspection was conducted concurrently with Critical Incident System inspection #2020_829757_0006 and Follow up inspection #2020_829757_0007.

PLEASE NOTE: Non-compliance related to s. 104 (1) 2. of O. Reg. 79/10 was identified during this inspection, and a Compliance Order (CO) was reissued in Follow up inspection report #2020_829757_0007.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Acting Director of Care (DOC), Resident Assessment Instrument (RAI) Coordinator, Environmental Manager, Dietary Manager, Office Manager, Registered Dietitian (RD), Nurse Practitioner (NP), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Quality Assistant (QA), Personal Support Workers (PSWs), Dietary Aide (DA), Activation Aide (AA), Housekeeping Aide, residents, and family members.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, staff-to-resident interactions,

resident-to-resident interactions, and reviewed relevant resident health care records, complaints records, internal investigation notes, as well as specific licensee policies, procedures, and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Falls Prevention
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Reporting and Complaints
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **14 WN(s)**
- **5 VPC(s)**
- **8 CO(s)**
- **2 DR(s)**
- **0 WAO(s)**

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

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

Specifically failed to comply with the following:

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

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 care set out in the plan of care was provided to residents as specified in the plan.

A complaint was received by the Director which outlined alleged neglect of care had occurred, resulting in an incident where resident #004 fell.

Inspector #687 reviewed the home's policy titled ,"Plan of Care – RC-05-01-01", last updated on June 2019, which indicated that "the resident plan of care [served] as a communication tool in which it [enhanced] the provision of individualized care; it [assisted] in the provision of continuity of care as all team members were aware of the individualized plan, and it [promoted] safe and effective resident care".

In a review of resident #004's electronic care plan in effect at the time of the incident, the plan stated that the resident required two staff members to assist the resident for a specified type of care.

During an interview conducted by Inspector #687 with Personal Support Worker (PSW) #107, they stated that they were providing care to resident #004 together

with PSW #115 on the day of the fall. However, PSW #107 indicated that PSW #115 had to leave resident #004 during care. PSW #107 stated that they had also left the resident momentarily to obtain a care product. When PSW #107 had returned to the resident, the PSW indicated they found the resident had fallen.

In an interview with Registered Nurse (RN) #106, the RN verified they had responded to resident #004's fall incident, and that the resident had sustained injuries as a result of the fall. The RN indicated that the resident required two staff members to assist during the specified type of care, and that PSW #107 had not followed the resident's plan of care.

During an interview conducted by Inspector #687 with the Acting Director of Care (DOC), they stated that resident #004 required two staff members to assist for the specified type of care. The Acting DOC further stated that when the fall incident involving resident #004 occurred, PSW #107 did not follow the plan of care for the resident. [s. 6. (7)]

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

A complaint was received by the Director, regarding the care of resident #001. Inspector #757 spoke to the complainant, who had concerns that the resident was not receiving adequate personal and grooming care.

Review of resident #001's latest care plan, last updated November 24, 2019, indicated that the resident required assistance with various areas of personal care.

Inspector #757 conducted a review of resident #001's Point of Care (POC) records for Day Care, Evening Care, and Night Care from October 1, 2019, to January 1, 2020. The review indicated that POC documentation had not been completed on the following days:

Day Care:
- October: nine days;
- November: two days;
- December: one day;
- January: one day.

Evening Care:
- October: nine days;
- November: five days;
- December: three days.

Night Care:
- October: nine days;
- November: nine days;
- December: four days.

Review of the home's policy "Daily Personal Care and Grooming – RC-06-01-01", last updated June 2019, identified that "care staff must document the care provided and any concerns regarding the condition of the resident must be reported to the nurse" and stated that care staff must "document care provided on Daily Care Record (DCR) or electronic equivalent to indicate care given or refused". The policy required care staff to "provide assistance with personal hygiene and grooming in accordance with assessed needs, at minimum, twice daily".

During an interview with PSW #112, they stated that documentation was not always completed in POC due to lack of staffing. The PSW stated that when this occurred, they were unable to tell which care tasks had been completed. Inspector #757 conducted an interview with PSW #127 who also stated that staff were sometimes unable to complete POC documentation due to lack of staffing and time.

Inspector #757 conducted an interview with the Acting DOC who stated that staff were expected to complete all POC documentation, and that staff were required to stay past their shift if documentation was not completed. They stated that POC documentation that was not completed indicated that care was either not provided or not documented. [s. 6. (9) 1.]

3. Review of resident #013's current care plan, last updated February 11, 2020, indicated that the resident required extensive assistance in various areas of personal care.

Inspector #757 conducted a review of resident #013's POC records for Day Care, Evening Care, and Night Care from December 8, 2019, to March 8, 2020. The review indicated that POC documentation had not been completed on the

following days:

Day Care:
- December: one day;
- January: two days.

Evening Care:
- December: two days;

Night Care:
- December: one day;
- January: five days;
- February: four days.

During an interview with PSW #112, they stated that documentation was not always completed in POC due to lack of staffing. The PSW stated that when this occurred, they were unable to tell which care tasks had been completed.

Inspector #757 conducted an interview with PSW #127 who also stated that staff were sometimes unable to complete POC documentation due to lack of staffing and time.

Inspector #757 conducted an interview with the Acting DOC who stated that staff were expected to complete all POC documentation, and that staff were required to stay past their shift if documentation was not completed. They stated that POC documentation that was not completed indicated that care was either not provided or not documented. [s. 6. (9) 1.]

4. A complaint was received by the Director, which outlined alleged neglect of care regarding resident #004's fall incident, continence care, and skin and wound care; as well as concerns related to insufficient staffing levels in the home.

During a review of resident #004’s POC task for a specified care intervention, the Inspector identified that the documentation for the intervention was not completed on the following instances:
- January 2020: three instances; and
- February 2020: 10 instances.

During a review of resident #004’s POC task for another specified care

intervention, the Inspector identified that the documentation for the intervention was not completed on the following days:
- January 2020: two days; and
- February 2020: five days.

During an interview with the Acting DOC, they acknowledged that there were obvious gaps in care documentation. The Acting DOC stated that their expectation from their PSW staff members was to document all care provided at the point of care. [s. 6. (9) 1.]

5. The licensee has failed to ensure that resident #002 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 changed or the care set out in the plan was no longer necessary.

A complaint was received by the Director alleging that resident #002 had broken equipment required for care and that the home would not repair or replace the equipment.

Inspector #196 conducted an interview with resident #002. They acknowledged that they were without their care equipment for a period of time in January 2020. They confirmed the equipment the resident had been using was not the resident's, and demonstrated the equipment was missing a specified safety device.

In a review of resident #002's health care records, the current care plan identified a specified intervention which required the missing safety device.

Inspector #196 conducted an interview with NP #110. They reported that the resident required a reassessment for the need of the safety device, indicating they may no longer have required it.

During an observation conducted together with the Acting DOC, resident #002 was observed using their care equipment without the safety device in place. The Acting DOC confirmed that the equipment the resident was using did not have the safety device, as their previous equipment had.

During an interview with the Resident Assessment Instrument (RAI) Coordinator, they reported that resident #002's current care equipment did not include the specified safety device. They further added that the registered staff were required

to reassess the resident and that this had not been done. [s. 6. (10) (b)]

Additional Required Actions:

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

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

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 provision of care set out in the plan of care is documented, and that residents are reassessed and the plan of care is 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 #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings, and equipment were maintained in a safe condition and in a good state of repair.

Inspector #757 spoke to a complainant who had concerns related to maintenance issues throughout the home.

During observations conducted throughout the home from March 2-6 and March 9 -12, 2020, Inspector #757 noted the following maintenance concerns:
- Second floor resident room: Loose grab bar in the bathroom; and the room's baseboard heater was missing a cover in an area accessible to residents, exposing the hot and sharp metal coil.
- Second floor resident room: Cracked counter in the bathroom, exposing a sharp laminate edge on the counter's top surface;
- Second floor resident room: Loose grab bar in the bathroom;
- Second floor resident room: Loose grab bar in the bathroom; Missing caulking along the edge of the bathroom sink, exposing corrosion and ceramic edges.
- Second-floor tub/shower room: Cracks and a chip to the bottom surface of the tub; Cracked surfaces to the shower floor;
- Third floor resident room: Corrosion along the edge of the bathroom sink, and exposed sharp ceramic edges of the sink;
- Third floor resident room: Hole in the bathroom's ceiling tile;
- Third floor resident room: Loose grab bar in the bathroom, hole present in the wall outside of the bathroom, large rust coloured water stain on sagging ceiling tile, several smaller ceiling tile water stains throughout room;
- Third floor resident room: Loose grab bar in the bathroom; Water stain to ceiling tile at the entrance to the room;
- Third-floor common area: Extensive water stains to ceiling tiles throughout third floor corridors and seating areas; ventilation vents with a build-up of black debris in the television seating area, and in the seating area in front of the nursing station; a missing ceiling tile in the television seating area; and cracked floor tiles in front of the elevator, and in the television seating area;
- Third floor, outside of the dirty utility room: Corner to the right of the door to the dirty utility room had visible black mould, water stains, and appeared to have rotted wood and peeling paint;
- Third-floor tub/shower room door: Lock on the door did not engage unless manually engaged after closing the door; noted the door to be accessible without entering the door code during four separate observations. The tub/shower room contained a disinfectant cleaner with a label that read: "WARNING: POISON: CORROSIVE".

Ontario Regulation (O. Reg.) 79/10, s. 90 (d) states “all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks”.

The Inspector conducted an interview with PSW #108 in the third-floor tub/shower room. The PSW stated that they had raised the issue of the door not functioning properly approximately six months prior with nursing staff, and that there had been an issue with one resident wandering into that tub/shower room.

During an interview with PSW #105, they stated that the cracks and chips in the second-floor tub/shower room had been there for an extended period of time.

Inspector #757 conducted a tour of all of the areas with maintenance concerns identified throughout the home together with the Environmental Manager, and confirmed with them all of the areas of concern.

The home’s “Maintenance Manual” stated that the maintenance program was to “maintain the facility and environment in a condition that provides for the comfort and safety of the occupants”, and “maintain the building and equipment in a good condition by detecting structural or equipment damage or failure and effecting timely repairs”.

The home's policy, "Remedial (Demand) Maintenance Program - MN-03-01-01", last updated July 2019, stated that "All homes shall have a remedial (demand) maintenance program that provides a system of routine inspections and repairs to the building components including the equipment and systems that are part of the building".

During an interview with the Environmental Manager, they indicated that they conducted a daily walk through of home areas, including resident areas that were not occupied at the time, but had not identified all of the issues identified during this inspection, or had not had time to rectify them. They stated that there had been a previous issue with a hot water tank which broke and had leaked, causing water damage to the home. They confirmed that this water damage was the likely cause of the mould noted outside of the third-floor dirty utility room, and that the water damage could have resulted in other mould issues throughout the home. They confirmed that the loose grab bars, improperly functioning third-floor tub/shower room door lock, and potential for mould due to water damage were all

safety concerns for residents. They indicated that the residents' right to live in a safe and clean environment had not been respected and that "going forward [they] will address this". The Environmental Manager also confirmed that the bathroom fixtures had not been kept free of corrosion and cracks, and that the identified areas of concern had not been maintained in a safe condition and good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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 that each resident of the home was 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.

During an observation conducted by Inspector #687 at 1506 hours, on March 9, 2020, Inspector #687 did not observe any PSW staff present along the hallway or nursing station on third floor home area.

In a review of the home's "Resident Care and Bath List" on March 9, 2020,

Inspector #687 identified eight residents who were scheduled for their baths during the day shift but did not receive one, including residents #004, #011, #014, and #015.

Inspector #687 conducted an interview with PSW #126. They stated that resident #004, #011, #014, #015, and four other residents had not received their scheduled bath on March 9, 2020 due to short staffing. The PSW further stated that there was only one PSW on the floor at that time.

During an interview with Registered Practical Nurse (RPN) #121, they verified to Inspector #687 that there were eight residents who did not receive their scheduled bath on March 9, 2020, including resident #015. The RPN stated that there was only one PSW on the floor at the time, who was identified as PSW #126. The RPN further stated that they had documented that there were six other residents from the previous shift on March 8, 2020, who had not received their scheduled bath.

In an interview with RN #106, the RN stated that residents were scheduled to have two baths a week. The RN stated that when a home area had only one PSW staff member working, the PSW staff could not offer baths as it would be difficult especially for residents that required a mechanical lift or two-staff assistance. The RN further indicated that when this occurred the residents scheduled baths would be cancelled and re-scheduled.

The home's policy, "Bathing, Showering and Water Temperature Monitoring – RC-06-01-02", last updated June 2019, stated that "residents [would] be offered a tub bath or shower, based on resident preference, twice per week, at minimum" and "may occur more frequently, as determined by the resident's hygiene requirements".

a) A complaint was received by the Director which outlined alleged neglect of care related to resident #004's skin and wound care and falls prevention; as well as concerns related to insufficient staffing levels in the home.

Inspector #687 reviewed the bathing records for resident #004 over a eight-week period, and identified that the resident had not received their minimum twice weekly baths during the following periods:
- Week 1: baths did not occur;
- Week 2: bath occurred once;

- Week 3: bath occurred once;
- Week 4: bath occurred once;
- Week 5: bath occurred once;
- Week 6: bath occurred once;
- Week 7: bath occurred once; and
- Week 8: bath occurred once;

The bathing records indicated either that a bath was provided to a resident or would indicate “activity did not occur”, “resident refused”, or “not applicable” if a bath was not provided that day, depending on the reason it did not occur.

b) Inspector #687 reviewed the bathing records for resident #011 over a five-week period, and identified that the resident had not received their minimum twice weekly baths during the following periods:
- Week 1: bath occurred once;
- Week 2: bath occurred once;
- Week 3: no baths occurred;
- Week 4: no baths occurred; and
- Week 5: no baths occurred.

c) Inspector #687 reviewed the bathing records for resident #014 over a five-week period, and identified that the resident had not received their minimum twice weekly baths during the following periods:
- Week 1: bath occurred once;
- Week 2: bath occurred once;
- Week 3: bath was refused once; no other bath days were identified;
- Week 4: bath occurred once; and
- Week 5: baths did not occur.

d) Inspector #687 reviewed the bathing records for resident #015 over a five-week period, and identified that the resident had not received their minimum twice weekly baths during the following periods:
- Week 1: bath occurred once;
- Week 2: bath occurred once;
- Week 3: bath occurred once;
- Week 4: bath occurred once; and
- Week 5: baths did not occur.

In an interview with the Executive Director (ED), they reviewed the bathing

records for resident #004 and confirmed they had not received twice weekly baths.

During an interview with the Acting DOC, they reviewed the bathing records for residents #011, #014, and #015 with Inspector #687 and confirmed the residents had not received twice weekly baths. They stated that residents were scheduled to have two baths per week. They further stated that for residents who missed their scheduled baths, the staff members had to notify the oncoming shift. They stated that if this progressed into the next day, the staff members had to make every effort to ensure that residents who missed their scheduled bath would receive the care required. They stated that an additional staff member would also be called in to assist with residents' baths but was unable to provide the date of the last time this had occurred.

e) A complaint was received by the Director regarding care concerns for resident #001.
Inspector #757 reviewed resident #001's bathing records over a 13-week period which indicated the following:
- Week 1: bath occurred once;
- Week 2: baths did not occur;
- Week 3: bath occurred twice (13 days between baths);
- Week 4: bath occurred once;
- Week 5: bath occurred once (10 days between baths);
- Week 6: bath occurred once;
- Week 7: bath occurred once (7 days between baths);
- Week 8: bath occurred once (9 days between baths);
- Week 9: bath occurred once (6 days between baths);
- Week 10: baths did not occur;
- Week 11: bath occurred twice (13 days between baths);
- Week 12: bath occurred once (5 days between baths); and
- Week 13: bath occurred once (6 days between baths).

During an interview conducted by Inspector #757 with PSW #119, they stated that staff were expected to reapproach a resident three separate times to ask for a bath if they were refusing, before notifying registered nursing staff to speak with the resident. The PSW indicated they were not always sure who had received a bath, stating that attempts to reapproach a resident were not consistently documented.

During an interview with the Acting DOC they stated that each resident was to receive a bath twice a week. Together with Inspector #757, the Acting DOC reviewed the bathing records for resident #001 and confirmed the resident had not received baths at least twice weekly. They stated that if a resident refused a bath, they were to be reapproached by separate staff members three times that day, and that the bath was to be endorsed to the following shift, or the following day, if it was not provided. They further stated that care staff were to continue trying to ensure that residents received their required twice weekly baths. The Acting DOC indicated that the lack of baths did not constitute an acceptable level of care for residents and that bathing was a basic right of residents that needed to be met. [s. 33. (1)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of resident care equipment and contact surfaces.

Inspector #757 spoke to a complainant who had concerns related to tubs not being cleaned between resident baths.

The home's policy, "Tubs and Showers – IC-02-01-14", last updated October 2019, stated that care staff were to "clean and disinfect the tub/shower and any equipment such as a shower chair or bath lift used during the bath, after each use".

During observations conducted by Inspector #757 in the home's second and third-floor tub/shower rooms, the following issues were noted:
- March 3, 2020: Sticky green residue present on a tub contact surface in a second-floor tub/shower room; grime on the bottom contact surface of the other second-floor tub room; approximately one inch of standing water had been left in a third-floor tub, the tub had not been cleaned or sanitized;
- March 5, 2020: A white liquid had been left on the shower bench of a second-floor shower, a used cloth remained in the shower, and a resident's clothes, brief, and towels had been left on the floor;
- March 6, 2020: Hairs, dirt, and grime in a second-floor tub and the same white liquid remained on the shower bench from the previous day; hairs and grime in a third-floor tub; and hairs and a pink liquid on the bottom surface of a third-floor shower;
- March 10, 2020: Hairs, soap, and grime in a second-floor shower; and hair, dirt, and grime in one third-floor shower; and hair, grime, and dirt on both the shower and tub surfaces of the other third-floor tub/shower room.

Inspector #757 conducted an interview with PSW #105, who stated that grime and dirt should not be left in tubs and that staff were required to fill tubs with disinfectant following a bath, and then use a brush to scrub out the tub surfaces.

During an interview with the Acting DOC, they stated that staff were required to clean and sanitize bathtubs and that this was expected to be completed following every bath. [s. 87. (2) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an adequate program of personal support services for the home to meet the assessed needs of residents.

A complaint was received by the Director which alleged that there were insufficient staffing levels in the home.

In a review conducted by Inspector #687 of the PSW staffing levels for the home between January 1 to 31, 2020, the Inspector identified that the home had a PSW staffing shortage for 12 days out of 31 days which was translated to a 39 per cent shortage of PSW staff over the identified dates.

Inspector #687 reviewed the PSW staffing levels for the home between February 1 to 29, 2020; the Inspector identified that the home had a PSW staff shortage for 22 days out of 29 days which was translated to 76 per cent shortage of PSW staff over the identified dates.

In a subsequent review of PSW staffing levels between March 1 to 10, 2020, Inspector #687 identified that the home had a PSW staff shortage for 10 days out of 10 which was translated to 100 per cent shortage of PSW staff for the identified dates.

A review of the Daily Communication Report obtained from the Executive Director on March 10, 2020, indicated that the home had a shortage of PSW staff on March 2, 4, 5, and 6, 2020.

During an observation conducted by Inspector #687 on March 4, 2020, at 1430 hours, resident #011 was observed walking towards the nursing station. The resident smelled like they had been incontinent, and there was no staff member present along the hallway or at the nursing station at that time.

In an interview conducted by Inspector #687 with PSW #108, they informed the Inspector that they had provided care to resident #011 at 0830 hours on March 4, 2020, and were not able to provide care to the resident after that time as they were short-staffed and were working as the only PSW on the home unit during that shift.

In another observation conducted by Inspector #687 on March 4, 2020, Inspector #687 heard an alarm in one resident’s room at 1432 hours and noted there were no staff members present along the hallway or at the nursing station at that time. The Inspector found resident #012 on the toilet and noted that their alarm had been triggered and rang for seven minutes before being responded to.

During an interview conducted by Inspector #687 with PSW #108 and RPN #112 on March 4, 2020, the staff members stated that resident #011 and #012 had not received care as required, as the home area had only one PSW staff working to care for 44 residents. The RPN further stated that it was clear neglect of care as they were unable to provide the care required for the residents at that time. Both staff members also stated that baths had not been provided for four residents who were scheduled for their baths at that time.

In a review of the home's "Resident Care and Bath List" document on the third-floor home area dated March 5, 2020, Inspector #687 identified eight residents who did not receive their scheduled bath.

In a subsequent review of the home's "Resident Care and Bath List" document on the third-floor home area dated March 8, 2020, Inspector #687 identified six residents who did not receive their scheduled bath.

In an interview with RN #106, the RN stated that residents were scheduled to have two baths a week. The RN stated that when a home area had only one PSW staff member working, the PSW staff could not offer baths as it would be difficult especially for residents that required a mechanical lift or two-staff assistance.

Inspector #757 conducted an interview with PSW #119 who stated that care was often affected due to insufficient staffing. They stated that "really it affects all of it, bathing, grooming, etc. – Especially with burnt out and lack of staff".

During an interview with RPN #112, they indicated to Inspector #757 that staff often could not complete documentation due to lack of staff and a subsequent lack of time, which made it difficult to track who had had care completed, and that staff were often unable to tell from the documentation if care had been provided to residents or not.

In an interview with the Acting DOC, regarding resident #011 on March 5, 2020, they stated, "I would say that the care was not provided. I can't deny that. But I guess, that leads to neglect". In a subsequent interview with the Acting DOC regarding resident #012 on March 5, 2020, the Acting DOC stated, "This was awful! A staff member should have informed me and the Executive Director about this. Regarding resident #012, I would say that the care was not provided. I can't deny that. But I guess, that leads to neglect. I just wish that I knew that".

In an additional interview with the Acting DOC regarding residents' missed scheduled baths, the Acting DOC stated that for residents who missed their scheduled baths, staff members had to notify the oncoming shift. They further stated that if this progressed onto the next day, the staff members had to make every effort to ensure that residents who missed their scheduled bath would receive the care required. The Acting DOC stated that a staff member would also be called to assist with residents' baths but was unable to provide the date of the

last time this had occurred.

Inspector #687 spoke to the ED regarding the Interdisciplinary Daily Communication Reports for March 2-6, 2020. The ED verified that a daily meeting at 0930 hours was held to discuss issues which included concerns regarding insufficient staffing levels in the home.

Further findings detailing the insufficient personal support services in the home are specified in WN #1 – 2. and 3., WN #3, and WN #6 – e) and f). [s. 8. (1) (b)]

2. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During the inspection, PSW #113 reported to Inspector #196 that RPN #121 had worked as the RN on Sunday night. They further reported that this RPN had worked Sunday (March 1, 2020) evening; then the night shift; and then was told to give out medications on the morning day shift; and had worked for over 18 hours. PSW #113 then provided a copy of the "compliment for staffing" that showed RPNs working in the RN role over the weekend.

A document titled, "Birchwood Terrace Nursing Home – Registered Nurse Staffing Back Up Plan – January 2016", was reviewed by the Inspector. The plan read, "If no registered staff member [was] able to accept the shift; then a registered practical nurse who [was] both an employee of the licensee and a member of the regular nursing staff may complete the shift with the provision that a registered nurse [was] available on call by telephone. [Staff member] will be on call."

During an interview, RPN #112 reported that they had worked the day shifts on February 29 and March 1, 2020, and confirmed there was no RN in the building.

In an interview, the Office Manager and RN #106, reported that the following shifts did not have an RN present and on duty in the home over the past two months:
- Feb 7, 2020, from 2300 to 0700 hours;
- Feb. 29, 2020, from 0700 hours through to 0700hrs March 1, 2020; and
- March 1, 2020, from 0700 hours to 0700 hours March 2, 2020.

They further added that on these shifts in which there was no RN present in the home, the Acting DOC was available by telephone.

In an interview with the Acting DOC, they reported that there were shifts in which an RN was not present and on duty in the home. They further added that the home always had an RPN and then had a RN available by phone; and that this was a part of the home's contingency plan. [s. 8. (3)]

Additional Required Actions:

CO # - 005, 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A5)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse from anyone and free from neglect by the staff in the home.

In a review of the policy for the home's Zero Tolerance of Resident Abuse and Neglect Program, last updated June 2019, the policy indicated that, "Extendicare was committed to provide [a] safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times". The policy further indicated that, "Extendicare has zero tolerance for abuse and neglect. Any form of abuse or neglect by a person, whether through deliberate acts of negligence, will not be tolerated".

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

A complaint was received by the Director which outlined alleged neglect of care related to resident #004's skin and wound care.

Inspector #687 conducted a review of the electronic progress notes related to resident #004's admission to the home. The resident was identified as having no skin impairment based on the head-to-toe assessment, but was categorized as at risk for altered skin integrity.

During a review of resident #004's documentation under "standard task", the Inspector noted it had been documented by the Acting DOC that the resident required a specified skin care intervention. Inspector #687 reviewed resident #004's care tasks for the month of October 2019 to identify a task for the resident's skin care intervention; however, the specified task could be identified.

On review of resident #004's electronic order, Inspector #687 identified that NP #110 had written an order for the resident's specified skin care intervention. The order was identified as not signed, processed or checked by any of the registered staff.

Inspector #687 reviewed the electronic progress notes written by the physician, which identified that resident #004 had impaired skin integrity.

A review of resident #004's electronic order, identified NP #110 had written another order for resident #004 to receive the specified skin care intervention. The Inspector identified this order had been processed late.

During an interview with RN #106 by Inspector #687, the RN verified that resident #004 had specific areas of impaired skin integrity.

In an interview conducted by Inspector #687 with NP #110, they stated that when resident #004 was admitted to the home, the resident had no skin impairment but was at risk for impaired skin integrity as the resident required a specified skin care intervention to be implemented. The NP further stated that they had discussed with staff members and management that the home had to formulate strategies for them to prevent impaired skin integrity from developing.

In an interview conducted by Inspector #687 with the Acting DOC, they acknowledged that resident #004 had no skin impairment upon admission to the home. Regarding resident #004's skin impairments, in relation to the NP orders not being processed in a timely manner, they stated that "The resident required assistance to [implement the skin care intervention]. When an MD or NP order was written, it should have been flagged for the registered staff and dealt with. That was not right!".

b) A complaint was received by the Director which outlined alleged neglect of care related to resident #004's fall incident.

During an interview conducted by Inspector #687 with PSW #107, they stated that on the day of the resident's fall, they were providing care to resident #004 and had left the resident to obtain a care product. The PSW further stated that when they had returned to the resident, they were found to have fallen. The PSW stated that they were regretful and remorseful of what had happened.

In a review of resident #004's electronic care plan in effect at the time of the incident, the care plan interventions included that the resident required two-staff for assistance when receiving the specified type of care being provided at the time of the fall.

In an interview with Registered Nurse (RN) #106, the RN verified they had responded to resident #004's fall incident, and that the resident had sustained injuries as a result the fall.

Inspector #687 conducted an interview with the Acting DOC. They stated that based on the home's internal investigation, the allegation of neglect by PSW #107

towards resident #004 was substantiated.

c) O. Reg. 79/10 defines verbal abuse as “any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident’s sense of well-being, dignity or self-worth, that is made by anyone other than a resident”; and physical abuse as “the use of physical force by anyone other than a resident that causes physical injury or pain”.

A CIS report was submitted to the Director as a result of an alleged incident of staff-to-resident abuse. The CIS report indicated that the Acting DOC received a call from the complainant stating that PSW #105 had been very rude to resident #006 and had thrown an object at them.

During an interview with Inspector #759, resident #006 indicated that a staff member threw the object at them.

Inspector #759 reviewed the home's investigation notes that related to this incident and identified a document that indicated that PSW #105 entered resident #006’s room, picked up the object, and threw it towards resident #006. It further indicated that PSW #105 stated to the resident that they wished they would stop calling for staff all the time.

Inspector #759 reviewed PSW #105’s employee file and identified a document which indicated that upon the outcome of the investigation, it was determined that PSW #105 had committed abuse to resident #006 as they had thrown the object at the resident. It further indicated that this incident was in violation of Extendicare’s abuse and neglect policy.

Inspector #759 conducted an interview with the Acting DOC, where they confirmed that PSW #105 failed to comply with the zero tolerance of abuse policy and that the abuse was substantiated.

d) O. Reg. 79/10 defines sexual abuse as “any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member”.

A Critical Incident System (CIS) report was submitted to the Director as a result of an alleged incident of staff-to-resident sexual abuse. The CIS report indicated that

PSW #109 had engaged in inappropriate sexual contact with resident #005.

Inspector #759 reviewed resident #005's electronic progress notes and identified a progress note written by RN #106. The note indicated that RN #106 spoke with resident #005, who indicated that PSW #109 had touched them inappropriately.

During an interview, RN #106 indicated to Inspector #759 that resident #005 reported to them what had happened, and that the RN immediately sent PSW #109 home as a result.

Inspector #759 reviewed the home's investigation notes related to the incident and identified that the allegation of PSW #109 sexual abuse toward resident #006 was consistent with the investigation notes.

Inspector #759 conducted an interview with the Acting DOC. They confirmed that PSW #109 had not complied with the zero tolerance of abuse policy and that the allegation of sexual abuse was substantiated.

e) During an observation conducted by Inspector #687 on March 4, 2020, at 1430 hours, resident #011 was observed walking towards the nursing station. The resident smelled like they had been incontinent, and there was no staff member present along the hallway or at the nursing station at that time.

In an interview conducted by Inspector #687 with PSW #108, they informed the Inspector that they had provided care to resident #011 at 0830 hours on March 4, 2020, and were not able to provide care to the resident after that time as they were short-staffed and were working alone in the home unit that shift.

During an interview with RPN #112, the RPN stated that resident #011 required assistance for care, but PSW #108 was not able to provide the care required for the resident on March 4, 2020. The RPN further stated that there was only one PSW staff member in the home area for 44 residents and that it was clear neglect of care as the staff were unable to provide the care required for the resident at that time.

Inspector #687 interviewed RN #106 and verified that the third-floor home area was short-staffed during the day shift on March 4, 2020. The RN further stated that a unit meeting was conducted daily at 0930 hours with the ED, the Acting DOC, RAI Coordinator, Physiotherapy Assistant, and Unit Managers. The RN

verified that the home's daily staffing level issues were discussed, and management was made aware.

In an interview with the Acting DOC, they stated that if a resident was required to have their continence care provided, a staff member, and generally the PSWs had to provide care. The Acting DOC further stated that "with regards to [resident #011], I would say that the care was not provided. I can't deny that. But I guess, that leads to neglect".

f) During an observation conducted by Inspector #687 on March 4, 2020, Inspector #687 heard an alarm in one resident's room at 1432 hours and noted there were no staff members present along the hallway or at the nursing station at that time. The Inspector found resident #012 on the toilet and noted that their alarm had been triggered and rang for seven minutes before being responded to.

In an interview conducted by Inspector #687 with PSW #108, they stated that resident #012 required assistance for care, and required the alarm for their safety. The PSW further stated that they did not hear the alarm when it rang as they may have been attending to another resident along the opposite hallway.

During an interview with RPN #112, they stated that resident #012 required assistance for care, but PSW #108 was not able to provide the care required for the resident as they were short-staffed and there was only one PSW on the floor to care for 44 residents. The RPN further stated that it was clear neglect of care as they were unable to provide the care required for the resident at that time.

In an interview with the Acting DOC, they stated that, "This was awful! A staff member should have informed me and the Executive Director about this. Regarding resident #012, I would say that the care was not provided. I can't deny that. But I guess, that leads to neglect. I just wish that I knew that". [s. 19. (1)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 007

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Findings/Faits saillants :

1. The licensee has failed to ensure that:
- For every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response was made to the person who made the complaint, indicating what the licensee had done to resolve the complaint; or that the licensee believed the complaint to be unfounded and the reasons for the belief. [s. 101 (1)]
- A documented record was kept in the home that included, that nature of each complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant. [s. 101 (2)]
- The documented complaints record was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record was kept of each review and of the improvements made in response. [s. 101 (3)]

a) A written complaint was received by the Acting DOC regarding the care of resident #001. The complaint alleged that when the complainant visited the home following a fall of resident #001, a specified falls prevention intervention was not working. The complainant also alleged that this was the third time during that week the falls prevention intervention had not been working when they visited the home. The complainant alleged that when they had presented the issue to staff,

staff had given the complainant “a myriad of excuses”, and indicated that staff did not know how to rectify the issue.

The home’s policy titled “Complaints and Customer Service – RC-09-01-04”, last updated June 2019, stated that the ED, Department Manager, or designate must “provide a written response at conclusion of investigation” to include “what the home has done to resolve the complaint” or “if the complaint is unfounded, the reasons why this conclusion was reached”. The policy also stated that “each contact with the complainant should be recorded on the Contact Log” by the person making the contact”.

The Acting DOC wrote a response letter to the complainant, which stated that staff were alerted to resident #001’s fall by the sound of the specified falls prevention intervention. The response letter made no mention that anything had been done to resolve the complainant’s concerns, or that they believed the complaint to be unfounded and the reasons for that belief, with regard to:
- The allegation that the falls prevention intervention had not been working when the complainant had visited the home, following resident #001’s fall, and two other times that same week; and
- The allegation that staff were unable to rectify the issue of the falls prevention intervention not working.

Inspector #757 conducted a record review of resident #001’s electronic health records. A progress note completed by RPN #112, stated they had “Heard a loud bang coming from the resident’s room. Went into the [their] room and found [they had fallen]”. The post-fall assessment was also reviewed. Neither the progress notes, or the post-fall assessment, made any mention of the specified falls prevention intervention alerting staff to the fall.

During an interview with the Acting DOC, Inspector #757 requested that they provide all of their documentation related to their investigation into the complaint. The Acting DOC stated that they had no documentation related to their investigation. They stated that during their investigation they “would have checked the records, [falls interventions], and made sure that things were in place” and “would have spoken to the charge nurse and the RPN working that day”; however, they were unable to name the charge nurse they had spoken to, and identified the RPN working that day only after reading resident #001’s electronic progress notes during the interview.

During an interview with RPN #112, they stated that they had initially responded to resident #001 following their fall on January 2, 2020. The RPN indicated that when they responded, the falls prevention intervention was in place; however, the intervention was not making a sound when they responded to the fall.

Inspector #757 conducted an interview with the Acting DOC, where they were asked how they were able to determine that the falls prevention intervention was functioning at the time of resident #001's fall, and why the complainant had been told this. They responded by saying "I'm just telling you what was relayed to me" and "I responded to [them] as I was told to" by the home's previous Executive Director. They confirmed that the letter of response had not included either what the home had done to resolve the complainant's specific complaints; or that they believed the complaints to be unfounded, and the reasons for that belief.

b) The home received a verbal complaint regarding a missing personal item belonging to resident #016.

The home's complaint investigation form noted that the home spoke with the complainant regarding the complaint; and investigated the complaint two days later; however, the form included no indication of a response ever being made to the complainant following the investigation. The form also stated that the personal item was unable to be located after a search of the resident's room, and following-up with housekeeping and laundry, but indicated that the complaint was unfounded despite the personal item not ever being located.

During an interview with the ED, they confirmed that the complaint investigation form made no mention of any response made to the complainant to indicate what was done to resolve the complaint, or to indicate that the complaint was unfounded and the reason for that belief.

c) The home's policy titled "Complaints and Customer Service – RC-09-01-04", last updated June 2019, stated that the ED, Department Manager, or designate must "Initiate an investigation into the circumstances leading to the complaint within 24 hours"; "Take notes of all interview questions, observations, and other actions related to the investigation"; "When possible, witness questions and statements should be written by the witness, dated and signed"; and "keep all materials related to the investigation together in one file for future retrieval and quality improvement auditing purposes".

A written complaint was received by the Acting DOC regarding the care of resident #001. The complaint alleged that when the complainant visited the home following a fall of resident #001, a specified falls prevention intervention was not working. The complainant also alleged that this was the third time during that week the falls prevention intervention had not been working when they visited the home. The complainant alleged that when they had presented the issue to staff, staff had given the complainant “a myriad of excuses”, and indicated that staff did not know how to rectify the issue.

The Inspector reviewed the home’s complaints binder, which contained only the e-mail correspondence between the home and the complainant, and included no other documentation.

During an interview with the Acting DOC, Inspector #757 requested that they provide their documentation related to their investigation into the complaint. The Acting DOC confirmed that they had completed no documentation related to their investigation or resolution of the complaint, and only had their e-mail correspondence with the complainant.

d) The home received a verbal complaint regarding a missing personal item belonging to resident #016.

Inspector #757 reviewed the home's complaint investigation form related to the complaint. The form included a brief description of the complaint, and a summary of the investigation and action taken with associated timeframes. However, the form did not indicate who the complaint was received from, indicating only their relation to the resident.

The complaint investigation form noted that the home spoke with the complainant to collect information regarding the complaint, and investigated the complaint two days later; however, the form makes no mention of a response ever being made to the complainant following their investigation, and the space for “completion date” was left blank. The “Contact Form” included in the complaint investigation form indicated that only “Laundry” and “Kitchen” were contacted following the home’s initial call with the complainant.

The complaint investigation form noted that the personal item was unable to be located after a search of the resident’s room, and after the home followed up with housekeeping and laundry staff, but indicated that the complaint was unfounded

despite the personal item not ever being located.

During an interview with the ED, they confirmed that the report did not include the complainant's name; every date a response was provided to the complainant, and a description of the response; and any response made in turn by the complainant.

e) The home received a verbal complaint regarding the care of resident #017, stating that the resident's specified skin care intervention had been turned off when they visited the home and that the resident's care equipment was uncomfortable. The complaint also included concerns regarding the maintenance and housekeeping of the home.

Inspector #757 reviewed the home's complaint investigation form regarding this complaint. The form included a brief description of the complaint, a summary of the investigation and actions taken with associated time frames. The form indicated that the complaint was founded, and that the complainant was contacted following the initial investigation. However, the form also indicated that follow-up action was required to resolve the complaint regarding the concerns around resident #017's care equipment, and that a separate person would have to be contacted regarding that portion of the complaint. Under the heading of "Attempts to Contact", the form indicated that one attempt to contact the other person was made and a message was left. The form indicated no further attempts at contact, and the space on the investigation form indicating "Date Completed" was blank.

During an interview with the ED, they confirmed that the final resolution of the complaint was not included in the documentation related to all the concerns indicated in the complaint.

f) During an interview with the Acting DOC, they stated that the home did not have records or a system to review and analyze complaint documentation in order to determine what improvements may need to be made to the home.

The ED provided Inspector #757 with a document titled "Complaints Tracker Extendicare 2019". The document included sheets for monthly tracking of all of the complaints received by the home, followed by a quarterly "Complaint Action Plan" to assess the effectiveness of the previous quarter's action plan, and included an analysis of complaint data for the immediate past quarter, actions to be taken going forward, and identified trends. The Inspector reviewed the home's Complaint Action Plans for the quarterly periods of April to June 2019; July to

September 2019; and October to December 2019, and identified that none of the analyses had any completed documentation.

During an interview with the ED, they confirmed that the document had not been completed, and that the complaint record had not been reviewed and analyzed for trends at least quarterly. [s. 101.]

Additional Required Actions:

CO # - 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all doors leading to non-residential areas were equipped with locks to restrict unsupervised access to those areas by residents, and those doors were kept closed and locked when they were not being supervised by staff.

The home's policy tilted "Door Surveillance and Secure Outdoor Areas – OP-04-01-04", last updated February 2020, stated that "doors leading to non-residential areas must be locked to restrict unsupervised access to those areas by non-staff"

and indicated that all staff were required to “keep doors to all non-resident areas locked and secure”.

a) During an observation of the home’s third floor on March 3, 2020, Inspector #757 was able to open the door to a tub/shower room, by turning the knob, but without first entering the code for the door’s lock. A bottle labelled “ARJO Disinfectant Cleanser IV” with a warning label indicating “WARNING: POISON: CORROSIVE” was located on the floor of the tub/shower room. On further observation, the Inspector noted that unless the door knob was manually turned after closing the door, the lock on the door would not engage, and could be opened again without first inputting the door code. During three subsequent observations of the same door on March 5, 10, and 11, 2020, the lock was found to be disengaged, and the tub/shower room was accessible to residents.

Inspector #757 conducted an interview with RPN #108 and demonstrated the issue to them. The PSW confirmed that the door was required to be locked, that they had raised the issue with a nurse approximately six months prior, and that there had been a previous issue with a resident who would wander into that tub/shower room.

During an interview with the Environmental Manager, they confirmed that this lock was not functioning properly and that it constituted a safety risk to residents.

b) While conducting an observation of the home’s second floor, Inspector #757 found that the door to file room #2 was unlocked and open. The room was noted to contain nursing supplies including scissors, hydrogen peroxide, gloves, and masks.

The Inspector conducted an interview with RPN #127 who confirmed that the door to file room #2 was required to be closed and locked.

c) During an observation of the home’s third floor, Inspector #757 noted that the door to file room #3 was unlocked and open, and was accessible to residents.

The Inspector conducted an interview with RPN #103 who confirmed that the door was required to be closed and locked, and stated that only management used that room.

d) During an observation of the home’s second floor on March 10, 2020, Inspector

#757 noted that the door to the clean utility room was unlocked. The Inspector conducted subsequent observations of this door on March 11 and 12, 2020, and found it again to have been left open and unlocked. The door to the room had two signs posted, that read “Please keep door closed at all times” and “Staff only”. The Inspector noted that the room contained electrical cables and charging stations for mechanical lifts, antiseptic alcohol solution, cleaning solution with a label that read “caution: causes eye and skin irritation”, and linens.

During an interview with Quality Assistant (QA) #125, they confirmed that the clean utility room door was required to be left closed and locked.

e) During an observation of the home’s second floor, Inspector #757 observed that the floor’s staff washroom was unlocked. The door to the washroom had a sign posted which read: “Staff Washroom: Remember to lock the door. It does not automatically lock”.

The Inspector conducted an interview with the ED who stated that all of these doors were expected to be kept closed and locked, and confirmed that staff had not complied with the home’s “Door Surveillance and Secure Outdoor Areas” policy. [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 those doors are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 59. Therapy services
Every licensee of a long-term care home shall ensure that therapy services for residents of the home are arranged or provided under section 9 of the Act that include,
(a) on-site physiotherapy provided to residents on an individualized basis or in a group setting based on residents' assessed care needs; and
(b) occupational therapy and speech-language therapy. O. Reg. 79/10, s. 59.

Findings/Faits saillants :

1. The licensee has failed to ensure that therapy services for residents of the home were arranged or provided under section 9 of the Act that included occupational therapy and speech-language therapy.

A complaint was received by the Director regarding the provision of care to resident #003, specific to a request for a referral to a specified type of health care professional.

During an interview with the complainant, they reported that they had been waiting for a referral for resident #003 for a specific assessment for over two months.

The health care records of resident #003 were reviewed. A progress note entered by Registered Dietitian (RD) #134 indicated that a referral to the specified health care professional had been requested due to a previous incident that had indicated a safety risk for the resident.

An order signed by RD #134 stated that the resident was to be referred for the specific assessment. An electronic progress note entered by the Acting DOC weeks after the complaint was lodged read “referral faxed to CCAC. Please follow up Nursing”. A further progress note dated a month later, read "Referral for [specified assessment] was faxed to CCAC. Nursing".

During an interview, the RAI Coordinator reported that the order for the assessment had not been processed correctly and registered staff had not followed up regarding this. They added that the registered staff should have followed up on this referral and ensured it was arranged to be completed. [s. 59. (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 therapy services for residents of the home are arranged or provided under section 9 of the Act that include occupational therapy and speech-language therapy, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no person would perform their responsibilities before receiving training for Zero Tolerance of Abuse and Neglect of residents.

A complaint was received by the Director which outlined alleged neglect of care regarding resident #004.

During a review of the home's staff training records for Zero Tolerance of Abuse and Neglect through Surge Learning, Inspector #687 identified three staff members who had not completed their orientation training.

Inspector #687 interviewed the Office Manager and verified the following staff members were hired but had not completed their training for Zero Tolerance of Abuse and Neglect:
- Dietary Manager;
- Dietary Aide; and
- PSW #131.

According to O. Reg. 79/10, section 221 (2), the licensee must ensure that all staff who provided direct care to residents received the training provided for in subsection 76 (7) of the Act based on the following: 1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. Subsection 76 (7) 1. indicates that training must be provided annually on abuse recognition and prevention.

In a review of the of the home's annual staff training records for Zero Tolerance of Abuse and Neglect through Surge Learning, Inspector #687 identified the same three staff members had not completed their annual training.

During an interview with the ED, they confirmed that the three staff members had not completed their orientation training for Zero Tolerance of Abuse and Neglect before performing their responsibilities, or at any time thereafter. The ED stated that the involved staff members were late in completing the training but would complete their training sometime that day (March 11, 2020). [s. 76. (2) 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 that no staff at the home performs their responsibilities before receiving training in the areas of: The Residents' Bill of Rights; the long-term care home's mission statement; the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; fire prevention and safety; emergency and evacuation procedures; infection prevention and control; all acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities; and any other areas provided for in the regulations, 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,
(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that heating, ventilation and air conditioning (HVAC) systems were cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation was kept of the inspection.

Inspector #757 spoke to a complainant who had concerns related to maintenance issues throughout the home.

During observations of the home's third floor, Inspector #757 noted an accumulation of black debris on the ventilation system's ceiling vents in the common areas above the television seating area and the seating area in front of the nursing station.

During an observation of a resident room, Inspector #757 noted that the room's baseboard heater was missing a cover and that the heater's sharp and hot coils were exposed, and accessible to residents.

Inspector #757 conducted a review of the home's "Maintenance Inspection" binder. The binder contained the following inspection forms:
- Heating (Specification Number 6760);
- Ventilation (Specification Number 6755); and
- Air Conditioning and Controls (Specification Number 6770).

Each form contained checklists of all inspection items to be inspected for each system; as well as spaces for the inspecting company to put their name, address, service inspector's name, signature, and date. The Inspector noted that none of the inspection forms in the Maintenance Inspection binder had been completed.

The Inspector requested documentation related to the required inspections of the home's HVAC systems from both the Environmental Manager and the ED. The Environmental Manager and the ED were unable to produce any of the home's inspection forms related to these inspections. The ED provided the Inspector with an invoice indicating that a "spring service" had been completed on the HVAC system April 17th, 2019, more than 10 months from the start of the inspection.

During an interview with the Environmental Manager, they stated that they were not aware of the legislative requirements regarding required inspections for the HVAC systems. The Inspector conducted an observation of the third-floor common area ventilation covers with the Environmental Manager who confirmed the buildup of debris. The Inspector also confirmed the missing baseboard heater cover with the Environmental Manager.

During an interview with the ED, they stated they were aware of the requirement to have HVAC inspections conducted every six months. They confirmed that the HVAC systems had not been serviced or inspected since April 2019. [s. 90. (2) (c)]

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 heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 65. Recreational and social activities program

Specifically failed to comply with the following:

s. 65. (2) Every licensee of a long-term care home shall ensure that the program includes,
(a) the provision of supplies and appropriate equipment for the program; O. Reg. 79/10, s. 65 (2).
(b) the development, implementation and communication to all residents and families of a schedule of recreation and social activities that are offered during days, evenings and weekends; O. Reg. 79/10, s. 65 (2).
(c) recreation and social activities that include a range of indoor and outdoor recreation, leisure and outings that are of a frequency and type to benefit all residents of the home and reflect their interests; O. Reg. 79/10, s. 65 (2).
(d) opportunities for resident and family input into the development and scheduling of recreation and social activities; O. Reg. 79/10, s. 65 (2).
(e) the provision of information to residents about community activities that may be of interest to them; and O. Reg. 79/10, s. 65 (2).
(f) assistance and support to permit residents to participate in activities that may be of interest to them if they are not able to do so independently. O. Reg. 79/10, s. 65 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the organized recreational and social activities program for the home included the development, implementation and communication to all residents and families of a schedule of recreation and social activities that were offered during days, evenings and weekends.

A complaint was received by the Director regarding the provision of recreational activities for resident #003.

During an interview with the complainant, they reported to the Inspector that there was only one activation staff member to provide recreational activities to all the residents in the home and that they were unable to meet the needs of resident #003.

The home’s policy titled, "Program Planning and Implementation – RV-03-01-01”, last updated April 2019, read the following:
- "An activity calendar will be developed and implemented with scheduled activities communicated to staff, residents, and family/SDM. Unless absolutely necessary, activities must not be canceled";
- "Create and post an activity calendar monthly. Ensure scheduled activity times allow for maximum number of residents to benefit";
- "Posting a monthly activity calendar in residents' rooms and common areas"; and
- "Remove the calendars on the last day of the month, replacing with the new calendar. The new calendar for the month should not be posted any later than the first day of the month".

In an interview with Inspector #196, AA #133 reported that they were unable to do everything, so they had focused on the larger activities, such as bingo, so more residents could be included. They stated they felt as though they were "leaving out so many people" but that they "just can't do everything".

The recreation calendar for the month of February 2020 was reviewed by Inspector #196 and Activation Aide #133. The Activation Aide confirmed that the following activities that were on the calendar were not provided to residents:
- The one-to-one scheduled in the morning on February 6, 13, 20, 27, was not provided as they worked on Thursday evenings;
- Bible study on Tuesdays in February;
- One-to-one programming on February 4, 10, 18, 19, and 21;

- The fun and fitness on February 5 and 7, was not provided as they worked evenings and this program was offered during the day time;
- Any activities on February 13 and 27;
- Singing on February 25; and
- Touch and talk on February 26 and 28.

In a further interview with Activation Aide #133, they indicated that the activity calendar for March 2020 had not been finalized as of March 5, 2020, as the calendar was awaiting review by the ED.

During an interview with the Acting DOC, they reported that they were unaware that the activities identified on the February 2020 activity calendar had not been provided to the residents. They added that at the home's morning meetings, AA #133 would report the activities for that day.

During an interview with the ED, they reported that the activity calendar for March 2020, was not completed as it was still awaiting additions. They further reported that AA #133 did not have computer access and required the assistance of the RAI Coordinator to complete this task. [s. 65. (2) (b)]

2. The licensee has failed to ensure that the organized recreational and social activities program for the home included assistance and support to permit residents to participate in activities that may be of interest to them if they were not able to do so independently.

A complaint was received by the Director regarding the lack of recreational activities provided to resident #003.

In an interview conducted by Inspector #196 with the complainant, they identified that resident #003 had specified health issues which limited the activities they could participate in. They added that the activation activities that were offered in the home were not appropriate for the resident; that there was only one activation staff member, and there had been four staff in the past; and that one-to-one activities did not occur often.

The home’s policy titled, "Program Planning and Implementation – RV-03-01-01”, last updated April 2019, read "Develop and implement activities that are based on resident assessments, care plans and activity goals". The policy stated that "an activity calendar [would] be developed and implemented with scheduled activities

communicated to staff, residents, and family/SDM. Unless absolutely necessary, activities must not be canceled".

A review of resident #003's health care records was conducted. The resident's current care plan regarding recreational programs, identified the resident was to receive specified types of activities.

During an interview with Activation Aide (AA) #133, they reported that they had been working alone in the recreation department since May 2019. They added that there were two program managers that had each worked in the department for a couple of months during this same period of time. The AA reported that for resident #003, a specified type of activity was ideal for them; however, they stated "only me in the department, so can't do it". They added that they were unable to do everything, so they focused on the larger activities, such as bingo, so more residents could be included. They stated they felt as though they were "leaving out so many people" but that they "just can't do everything".

The recreation calendar for the month of February 2020, was reviewed by Inspector #196 and AA #133. The AA confirmed that various activities on 12 different dates, that were planned to be provided to resident #003, were not provided.

During an interview with the Acting DOC, they reported that there was a lack of staffing in the recreation program and confirmed that there was only one Activation Aide employed. When questioned if they were aware of calendar activities not provided to the residents, they stated they were not aware of any activities that had not been provided. [s. 65. (2) (f)]

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 66. Designated lead

Specifically failed to comply with the following:

s. 66. (1) Every licensee of a long-term care home shall ensure that there is a designated lead for the recreational and social activities program. O. Reg. 79/10, s. 66 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a designated lead for the recreational and social activities program.

A complaint was received by the Director regarding the provision of recreational activities for resident #003.

During an interview with the complainant, they reported to the Inspector there was only one activation staff member to provide recreational activities to all the residents in the home.

In an interview with Activation Aide #133, they reported that at the time of the inspection, there was no recreational and social activities department manager. They added that since May 2019, there had been two separate recreational and social activities department managers that had worked at the home for periods of approximately two months each.

During an interview with the Acting DOC on March 4, 2020, they reported that the home was in the process of hiring a program manager for the recreational and social activities department. [s. 66. (1)]

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that all hazardous substances in the home were kept inaccessible to residents at all times.

During an observation of the home's third floor on March 3, 2020, Inspector #757 was able to open the door to a tub/shower room, by turning the knob, but without first entering the code for the door's lock. A bottle for a hazardous substance labelled "ARJO Disinfectant Cleanser IV" with a warning label indicating "WARNING: POISON: CORROSIVE" was located on the floor of the tub/shower room. On further observation, the Inspector noted that unless the door knob was manually turned after closing the door, the lock on the door would not engage, and could be opened again without first inputting the door code. During three subsequent observations of the same door on March 5, 10, and 11, 2020, the lock was found to be disengaged, and the hazardous substance was accessible to residents.

Inspector #757 conducted an interview with RPN #108 and demonstrated the issue to them. The PSW confirmed that the door was required to be locked and inaccessible to residents. They stated they had raised the issue with a nurse approximately six months prior, and that there had been a previous issue with a resident who would wander into that tub/shower room.

During an interview with the Environmental Manager, they confirmed that this lock was not functioning properly, that the hazardous substance was accessible to residents, and that it constituted a safety risk to residents. [s. 91.]

Issued on this 7 th day of January, 2021 (A5)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DAVID SCHAEFER (757) - (A5)
Inspection No. / No de l'inspection :	2020_829757_0008 (A5)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	000123-20, 000793-20, 001117-20, 003017-20 (A5)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 07, 2021(A5)
Licensee / Titulaire de permis :	CVH (No. 2) LP 766 Hespeler Road, Suite 301, c/o Southbridge Care Homes, Cambridge, ON, N3H-5L8
LTC Home / Foyer de SLD :	Birchwood Terrace 237 Lakeview Drive, R.R. #1, Kenora, ON, P9N-4J7
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marva Griffiths

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To CVH (No. 2) LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with s. 6 (7) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must ensure that the care set out in resident #004, and all other residents' plan of care is provided to the residents as specified in their plan of care.

Grounds / Motifs :

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

A complaint was received by the Director which outlined alleged neglect of care had occurred, resulting in an incident where resident #004 fell.

Inspector #687 reviewed the home's policy titled ,"Plan of Care – RC-05-01-01", last updated on June 2019, which indicated that "the resident plan of care [served] as a communication tool in which it [enhanced] the provision of individualized care; it [assisted] in the provision of continuity of care as all team members were aware of the individualized plan, and it [promoted] safe and effective resident care".

In a review of resident #004's electronic care plan in effect at the time of the incident, the plan stated that the resident required two staff members to assist the resident for a specified type of care.

During an interview conducted by Inspector #687 with Personal Support Worker

(PSW) #107, they stated that they were providing care to resident #004 together with PSW #115 on the day of the fall. However, PSW #107 indicated that PSW #115 had to leave resident #004 during care. PSW #107 stated that they had also left the resident momentarily to obtain a care product. When PSW #107 had returned to the resident, the PSW indicated they found the resident had fallen.

In an interview with Registered Nurse (RN) #106, the RN verified they had responded to resident #004's fall incident, and that the resident had sustained injuries as a result of the fall. The RN indicated that the resident required two staff members to assist during the specified type of care, and that PSW #107 had not followed the resident's plan of care.

During an interview conducted by Inspector #687 with the Acting Director of Care (DOC), they stated that resident #004 required two staff members to assist for the specified type of care. The Acting DOC further stated that when the fall incident involving resident #004 occurred, PSW #107 did not follow the plan of care for the resident.

The decision to issue a Compliance Order (CO) was based on the severity of the issue, which was a level 3, indicating actual harm. The scope of the issue was a level 1, indicating the issue was isolated. The home's compliance history related to the issue was a level 3, indicating previous non-compliance to the same subsection:
- VPC issued June 1, 2018, in inspection report #2018_624196_0011. (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 05, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Order / Ordre :

The licensee must comply with s. 15 (2) (c) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must:

a) Conduct an audit of all resident rooms, washrooms, common areas, and tub/shower rooms, and make repairs where water damage; mould; cracked tiles; holes in walls and ceilings; missing baseboard heater covers; cracked counters, fixtures, equipment; corrosion; and any other maintenance issues are identified.

b) Conduct an audit of all grab bars in the home and secure grab bars where required.

c) Conduct an audit of all door locks leading to tub/shower rooms and non-resident areas and make repairs where required.

d) Maintain documentation of all of the above audits and repairs, including the dates they were completed.

Grounds / Motifs :

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

1. The licensee has failed to ensure that the home, furnishings, and equipment were maintained in a safe condition and in a good state of repair.

Inspector #757 spoke to a complainant who had concerns related to maintenance issues throughout the home.

During observations conducted throughout the home from March 2-6 and March 9-12, 2020, Inspector #757 noted the following maintenance concerns:
- Second floor resident room: Loose grab bar in the bathroom; and the room's baseboard heater was missing a cover in an area accessible to residents, exposing the hot and sharp metal coil.
- Second floor resident room: Cracked counter in the bathroom, exposing a sharp laminate edge on the counter's top surface;
- Second floor resident room: Loose grab bar in the bathroom;
- Second floor resident room: Loose grab bar in the bathroom; Missing caulking along the edge of the bathroom sink, exposing corrosion and ceramic edges.
- Second-floor tub/shower room: Cracks and a chip to the bottom surface of the tub; Cracked surfaces to the shower floor;
- Third floor resident room: Corrosion along the edge of the bathroom sink, and exposed sharp ceramic edges of the sink;
- Third floor resident room: Hole in the bathroom's ceiling tile;
- Third floor resident room: Loose grab bar in the bathroom, hole present in the wall outside of the bathroom, large rust coloured water stain on sagging ceiling tile, several smaller ceiling tile water stains throughout room;
- Third floor resident room: Loose grab bar in the bathroom; Water stain to ceiling tile at the entrance to the room;
- Third-floor common area: Extensive water stains to ceiling tiles throughout third floor corridors and seating areas; ventilation vents with a build-up of black debris in the television seating area, and in the seating area in front of the nursing station; a missing ceiling tile in the television seating area; and cracked floor tiles in front of the elevator, and in the television seating area;
- Third floor, outside of the dirty utility room: Corner to the right of the door to the dirty utility room had visible black mould, water stains, and appeared to have rotted wood and peeling paint;
- Third-floor tub/shower room door: Lock on the door did not engage unless manually engaged after closing the door; noted the door to be accessible without entering the door code during four separate observations. The tub/shower room contained a

disinfectant cleaner with a label that read: "WARNING: POISON: CORROSIVE".

Ontario Regulation (O. Reg.) 79/10, s. 90 (d) states "all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks".

The Inspector conducted an interview with PSW #108 in the third-floor tub/shower room. The PSW stated that they had raised the issue of the door not functioning properly approximately six months prior with nursing staff, and that there had been an issue with one resident wandering into that tub/shower room.

During an interview with PSW #105, they stated that the cracks and chips in the second-floor tub/shower room had been there for an extended period of time.

Inspector #757 conducted a tour of all of the areas with maintenance concerns identified throughout the home together with the Environmental Manager, and confirmed with them all of the areas of concern.

The home's "Maintenance Manual" stated that the maintenance program was to "maintain the facility and environment in a condition that provides for the comfort and safety of the occupants", and "maintain the building and equipment in a good condition by detecting structural or equipment damage or failure and effecting timely repairs".

The home's policy, "Remedial (Demand) Maintenance Program - MN-03-01-01", last updated July 2019, stated that "All homes shall have a remedial (demand) maintenance program that provides a system of routine inspections and repairs to the building components including the equipment and systems that are part of the building".

During an interview with the Environmental Manager, they indicated that they conducted a daily walk through of home areas, including resident areas that were not occupied at the time, but had not identified all of the issues identified during this inspection, or had not had time to rectify them. They stated that there had been a previous issue with a hot water tank which broke and had leaked, causing water damage to the home. They confirmed that this water damage was the likely cause of the mould noted outside of the third-floor dirty utility room, and that the water damage

could have resulted in other mould issues throughout the home. They confirmed that the loose grab bars, improperly functioning third-floor tub/shower room door lock, and potential for mould due to water damage were all safety concerns for residents. They indicated that the residents' right to live in a safe and clean environment had not been respected and that "going forward [they] will address this". The Environmental Manager also confirmed that the bathroom fixtures had not been kept free of corrosion and cracks, and that the identified areas of concern had not been maintained in a safe condition and good state of repair.

The decision to issue a CO was based on the scope of the issue, which was a level 3, indicating the issue was widespread. The severity of the issue was a level 2, indicating risk for actual harm. The home's compliance history related to the issue was a level 3, indicating previous non-compliance to the same subsection:
- VPC issued November 14, 2018, in inspection report #2018_740621_0023;
- CO #002 issued August 3, 2017, in inspection report # 2017_652625_0010, and complied May 24, 2018. (757)

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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 comply with s. 33 (1) of Ontario Regulation 79/10.

Specifically, the licensee must:

a) Ensure that residents #001, #004, #011, #014, #015, and all other residents are 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.

b) Develop a documented auditing system to track which residents have not received a bath on their scheduled days, communicate this with direct care staff, and follow-up to ensure bathing requirements are met.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was 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.

During an observation conducted by Inspector #687 at 1506 hours, on March 9, 2020, Inspector #687 did not observe any PSW staff present along the hallway or nursing station on third floor home area.

In a review of the home's "Resident Care and Bath List" on March 9, 2020, Inspector #687 identified eight residents who were scheduled for their baths during the day shift but did not receive one, including residents #004, #011, #014, and #015.

Inspector #687 conducted an interview with PSW #126. They stated that resident #004, #011, #014, #015, and four other residents had not received their scheduled bath on March 9, 2020 due to short staffing. The PSW further stated that there was only one PSW on the floor at that time.

During an interview with Registered Practical Nurse (RPN) #121, they verified to Inspector #687 that there were eight residents who did not receive their scheduled bath on March 9, 2020, including resident #015. The RPN stated that there was only one PSW on the floor at the time, who was identified as PSW #126. The RPN further stated that they had documented that there were six other residents from the previous shift on March 8, 2020, who had not received their scheduled bath.

In an interview with RN #106, the RN stated that residents were scheduled to have two baths a week. The RN stated that when a home area had only one PSW staff member working, the PSW staff could not offer baths as it would be difficult especially for residents that required a mechanical lift or two-staff assistance. The RN further indicated that when this occurred the residents scheduled baths would be cancelled and re-scheduled.

The home's policy, "Bathing, Showering and Water Temperature Monitoring – RC-06 -01-02", last updated June 2019, stated that "residents [would] be offered a tub bath or shower, based on resident preference, twice per week, at minimum" and "may occur more frequently, as determined by the resident's hygiene requirements".

a) A complaint was received by the Director which outlined alleged neglect of care related to resident #004's skin and wound care and falls prevention; as well as concerns related to insufficient staffing levels in the home.

Inspector #687 reviewed the bathing records for resident #004 over a eight-week period, and identified that the resident had not received their minimum twice weekly baths during the following periods:
- Week 1: baths did not occur;
- Week 2: bath occurred once;

- Week 3: bath occurred once;
- Week 4: bath occurred once;
- Week 5: bath occurred once;
- Week 6: bath occurred once;
- Week 7: bath occurred once; and
- Week 8: bath occurred once;

The bathing records indicated either that a bath was provided to a resident or would indicate "activity did not occur", "resident refused", or "not applicable" if a bath was not provided that day, depending on the reason it did not occur.

b) Inspector #687 reviewed the bathing records for resident #011 over a five-week period, and identified that the resident had not received their minimum twice weekly baths during the following periods:
- Week 1: bath occurred once;
- Week 2: bath occurred once;
- Week 3: no baths occurred;
- Week 4: no baths occurred; and
- Week 5: no baths occurred.

c) Inspector #687 reviewed the bathing records for resident #014 over a five-week period, and identified that the resident had not received their minimum twice weekly baths during the following periods:
- Week 1: bath occurred once;
- Week 2: bath occurred once;
- Week 3: bath was refused once; no other bath days were identified;
- Week 4: bath occurred once; and
- Week 5: baths did not occur.

d) Inspector #687 reviewed the bathing records for resident #015 over a five-week period, and identified that the resident had not received their minimum twice weekly baths during the following periods:
- Week 1: bath occurred once;
- Week 2: bath occurred once;
- Week 3: bath occurred once;
- Week 4: bath occurred once; and
- Week 5: baths did not occur.

In an interview with the Executive Director (ED), they reviewed the bathing records for resident #004 and confirmed they had not received twice weekly baths.

During an interview with the Acting DOC, they reviewed the bathing records for residents #011, #014, and #015 with Inspector #687 and confirmed the residents had not received twice weekly baths. They stated that residents were scheduled to have two baths per week. They further stated that for residents who missed their scheduled baths, the staff members had to notify the oncoming shift. They stated that if this progressed into the next day, the staff members had to make every effort to ensure that residents who missed their scheduled bath would receive the care required. They stated that an additional staff member would also be called in to assist with residents' baths but was unable to provide the date of the last time this had occurred.

e) A complaint was received by the Director regarding care concerns for resident #001.
Inspector #757 reviewed resident #001's bathing records over a 13-week period which indicated the following:
- Week 1: bath occurred once;
- Week 2: baths did not occur;
- Week 3: bath occurred twice (13 days between baths);
- Week 4: bath occurred once;
- Week 5: bath occurred once (10 days between baths);
- Week 6: bath occurred once;
- Week 7: bath occurred once (7 days between baths);
- Week 8: bath occurred once (9 days between baths);
- Week 9: bath occurred once (6 days between baths);
- Week 10: baths did not occur;
- Week 11: bath occurred twice (13 days between baths);
- Week 12: bath occurred once (5 days between baths); and
- Week 13: bath occurred once (6 days between baths).

During an interview conducted by Inspector #757 with PSW #119, they stated that staff were expected to reapproach a resident three separate times to ask for a bath if they were refusing, before notifying registered nursing staff to speak with the resident. The PSW indicated they were not always sure who had received a bath,

stating that attempts to reapproach a resident were not consistently documented.

During an interview with the Acting DOC they stated that each resident was to receive a bath twice a week. Together with Inspector #757, the Acting DOC reviewed the bathing records for resident #001 and confirmed the resident had not received baths at least twice weekly. They stated that if a resident refused a bath, they were to be reapproached by separate staff members three times that day, and that the bath was to be endorsed to the following shift, or the following day, if it was not provided. They further stated that care staff were to continue trying to ensure that residents received their required twice weekly baths. The Acting DOC indicated that the lack of baths did not constitute an acceptable level of care for residents and that bathing was a basic right of residents that needed to be met.

The decision to issue a CO was based on the scope of the issue, which was a level 3, indicating the issue was widespread. The severity of the issue was a level 2, indicating risk for actual harm. The home's compliance history related to the issue was a level 3, indicating previous non-compliance to the same subsection:
- VPC issued June 1, 2018, in inspection report #2018_624196_0011. (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 05, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee must comply with s. 87 (2) (b) of Ontario Regulation 79/10.

Specifically, the licensee must ensure that resident tubs and showers are cleaned and disinfected following every bath or shower.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were implemented for cleaning and disinfection of resident care equipment and contact surfaces.

Inspector #757 spoke to a complainant who had concerns related to tubs not being cleaned between resident baths.

The home's policy, "Tubs and Showers – IC-02-01-14", last updated October 2019, stated that care staff were to "clean and disinfect the tub/shower and any equipment such as a shower chair or bath lift used during the bath, after each use".

During observations conducted by Inspector #757 in the home's second and third-floor tub/shower rooms, the following issues were noted:
- March 3, 2020: Sticky green residue present on a tub contact surface in a second-floor tub/shower room; grime on the bottom contact surface of the other second-floor tub room; approximately one inch of standing water had been left in a third-floor tub, the tub had not been cleaned or sanitized;
- March 5, 2020: A white liquid had been left on the shower bench of a second-floor shower, a used cloth remained in the shower, and a resident's clothes, brief, and towels had been left on the floor;
- March 6, 2020: Hairs, dirt, and grime in a second-floor tub and the same white liquid remained on the shower bench from the previous day; hairs and grime in a third-floor tub; and hairs and a pink liquid on the bottom surface of a third-floor shower;
- March 10, 2020: Hairs, soap, and grime in a second-floor shower; and hair, dirt, and grime in one third-floor shower; and hair, grime, and dirt on both the shower and tub surfaces of the other third-floor tub/shower room.

Inspector #757 conducted an interview with PSW #105, who stated that grime and dirt should not be left in tubs and that staff were required to fill tubs with disinfectant following a bath, and then use a brush to scrub out the tub surfaces.

During an interview with the Acting DOC, they stated that staff were required to clean and sanitize bathtubs and that this was expected to be completed following every bath.

The decision to issue a CO was based on the scope of the issue, which was a level 3, indicating the issue was widespread. The severity of the issue was a level 2, indicating risk for actual harm. The home's compliance history related to the issue was a level 3, indicating previous non-compliance to the same subsection:

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

- VPC issued November 14, 2018, in inspection report #2018_740621_0023. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Aug 05, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must comply with s. 8 (1) (b) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must ensure that there is an organized program of personal support services for the home to meet the assessed needs of all residents.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an adequate program of personal support services for the home to meet the assessed needs of residents.

A complaint was received by the Director which alleged that there were insufficient staffing levels in the home.

In a review conducted by Inspector #687 of the PSW staffing levels for the home between January 1 to 31, 2020, the Inspector identified that the home had a PSW staffing shortage for 12 days out of 31 days which was translated to a 39 per cent shortage of PSW staff over the identified dates.

Inspector #687 reviewed the PSW staffing levels for the home between February 1 to 29, 2020; the Inspector identified that the home had a PSW staff shortage for 22

days out of 29 days which was translated to 76 per cent shortage of PSW staff over the identified dates.

In a subsequent review of PSW staffing levels between March 1 to 10, 2020, Inspector #687 identified that the home had a PSW staff shortage for 10 days out of 10 which was translated to 100 per cent shortage of PSW staff for the identified dates.

A review of the Daily Communication Report obtained from the Executive Director on March 10, 2020, indicated that the home had a shortage of PSW staff on March 2, 4, 5, and 6, 2020.

During an observation conducted by Inspector #687 on March 4, 2020, at 1430 hours, resident #011 was observed walking towards the nursing station. The resident smelled like they had been incontinent, and there was no staff member present along the hallway or at the nursing station at that time.

In an interview conducted by Inspector #687 with PSW #108, they informed the Inspector that they had provided care to resident #011 at 0830 hours on March 4, 2020, and were not able to provide care to the resident after that time as they were short-staffed and were working as the only PSW on the home unit during that shift.

In another observation conducted by Inspector #687 on March 4, 2020, Inspector #687 heard an alarm in one resident's room at 1432 hours and noted there were no staff members present along the hallway or at the nursing station at that time. The Inspector found resident #012 on the toilet and noted that their alarm had been triggered and rang for seven minutes before being responded to.

During an interview conducted by Inspector #687 with PSW #108 and RPN #112 on March 4, 2020, the staff members stated that resident #011 and #012 had not received care as required, as the home area had only one PSW staff working to care for 44 residents. The RPN further stated that it was clear neglect of care as they were unable to provide the care required for the residents at that time. Both staff members also stated that baths had not been provided for four residents who were scheduled for their baths at that time.

In a review of the home's "Resident Care and Bath List" document on the third-floor

home area dated March 5, 2020, Inspector #687 identified eight residents who did not receive their scheduled bath.

In a subsequent review of the home's "Resident Care and Bath List" document on the third-floor home area dated March 8, 2020, Inspector #687 identified six residents who did not receive their scheduled bath.

In an interview with RN #106, the RN stated that residents were scheduled to have two baths a week. The RN stated that when a home area had only one PSW staff member working, the PSW staff could not offer baths as it would be difficult especially for residents that required a mechanical lift or two-staff assistance.

Inspector #757 conducted an interview with PSW #119 who stated that care was often affected due to insufficient staffing. They stated that "really it affects all of it, bathing, grooming, etc. – Especially with burnt out and lack of staff".

During an interview with RPN #112, they indicated to Inspector #757 that staff often could not complete documentation due to lack of staff and a subsequent lack of time, which made it difficult to track who had had care completed, and that staff were often unable to tell from the documentation if care had been provided to residents or not.

In an interview with the Acting DOC, regarding resident #011 on March 5, 2020, they stated, "I would say that the care was not provided. I can't deny that. But I guess, that leads to neglect". In a subsequent interview with the Acting DOC regarding resident #012 on March 5, 2020, the Acting DOC stated, "This was awful! A staff member should have informed me and the Executive Director about this. Regarding resident #012, I would say that the care was not provided. I can't deny that. But I guess, that leads to neglect. I just wish that I knew that".

In an additional interview with the Acting DOC regarding residents' missed scheduled baths, the Acting DOC stated that for residents who missed their scheduled baths, staff members had to notify the oncoming shift. They further stated that if this progressed onto the next day, the staff members had to make every effort to ensure that residents who missed their scheduled bath would receive the care required. The Acting DOC stated that a staff member would also be called to assist with residents' baths but was unable to provide the date of the last time this had occurred.

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

Inspector #687 spoke to the ED regarding the Interdisciplinary Daily Communication Reports for March 2-6, 2020. The ED verified that a daily meeting at 0930 hours was held to discuss issues which included concerns regarding insufficient staffing levels in the home.

Further findings detailing the insufficient personal support services in the home are specified in WN #1 – 2. and 3., WN #3, and WN #6 – e) and f).

The decision to issue a CO was based on the scope of the issue which was a level 3, indicating the issue was widespread. The severity of the issue was a level 3, indicating actual harm. The home's compliance history related to the issue was a level 3, indicating previous non-compliance to the same subsection:
- CO #001 issued June 1, 2018, in inspection report #2018_624196_0011, and complied October 5, 2018. (687)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2021(A5)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 006

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must comply with s. 8 (3) of the Long-Term Care Homes Act, 2007.

Specifically, the licensee must ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times, except as provided for in the regulations.

During the inspection, PSW #113 reported to Inspector #196 that RPN #121 had worked as the RN on Sunday night. They further reported that this RPN had worked Sunday (March 1, 2020) evening; then the night shift; and then was told to give out medications on the morning day shift; and had worked for over 18 hours. PSW #113 then provided a copy of the "compliment for staffing" that showed RPNs working in the RN role over the weekend.

A document titled, "Birchwood Terrace Nursing Home – Registered Nurse Staffing Back Up Plan – January 2016", was reviewed by the Inspector. The plan read, "If no

registered staff member [was] able to accept the shift; then a registered practical nurse who [was] both an employee of the licensee and a member of the regular nursing staff may complete the shift with the provision that a registered nurse [was] available on call by telephone. [Staff member] will be on call."

During an interview, RPN #112 reported that they had worked the day shifts on February 29 and March 1, 2020, and confirmed there was no RN in the building.

In an interview, the Office Manager and RN #106, reported that the following shifts did not have an RN present and on duty in the home over the past two months:
- Feb 7, 2020, from 2300 to 0700 hours;
- Feb. 29, 2020, from 0700 hours through to 0700hrs March 1, 2020; and
- March 1, 2020, from 0700 hours to 0700 hours March 2, 2020.

They further added that on these shifts in which there was no RN present in the home, the Acting DOC was available by telephone.

In an interview with the Acting DOC, they reported that there were shifts in which an RN was not present and on duty in the home. They further added that the home always had an RPN and then had a RN available by phone; and that this was a part of the home's contingency plan.

The decision to issue a CO was based on the scope of the issue which was a level 3, indicating the issue was widespread. The severity of the issue was a level 2, indicating risk of harm. The home's compliance history related to the issue was a level 3, indicating previous non-compliance to the same subsection:
- Director's Referral (DR)/CO #001 issued November 14, 2018, in inspection report #2018_740621_0023, and complied April 10, 2019;
- DR/CO #001 issued June 1, 2018 issued June 1, 2018, in inspection report #2018_624196_0012;
- CO #001 issued August 3, 2017, in inspection report #2017_652625_0010. (196)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 03, 2020(A3)

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 007

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must ensure that residents of the home are protected from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse from anyone and free from neglect by the staff in the home.

In a review of the policy for the home's Zero Tolerance of Resident Abuse and Neglect Program, last updated June 2019, the policy indicated that, "Extendicare was committed to provide [a] safe and secure environment in which all residents were treated with dignity and respect and protected from all forms of abuse or neglect at all times". The policy further indicated that, "Extendicare has zero tolerance for abuse and neglect. Any form of abuse or neglect by a person, whether through deliberate acts of negligence, will not be tolerated".

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

A complaint was received by the Director which outlined alleged neglect of care

related to resident #004's skin and wound care.

Inspector #687 conducted a review of the electronic progress notes related to resident #004's admission to the home. The resident was identified as having no skin impairment based on the head-to-toe assessment, but was categorized as at risk for altered skin integrity.

During a review of resident #004's documentation under "standard task", the Inspector noted it had been documented by the Acting DOC that the resident required a specified skin care intervention. Inspector #687 reviewed resident #004's care tasks for the month of October 2019 to identify a task for the resident's skin care intervention; however, the specified task could be identified.

On review of resident #004's electronic order, Inspector #687 identified that NP #110 had written an order for the resident's specified skin care intervention. The order was identified as not signed, processed or checked by any of the registered staff.

Inspector #687 reviewed the electronic progress notes written by the physician, which identified that resident #004 had impaired skin integrity.

A review of resident #004's electronic order, identified NP #110 had written another order for resident #004 to receive the specified skin care intervention. The Inspector identified this order had been processed late.

During an interview with RN #106 by Inspector #687, the RN verified that resident #004 had specific areas of impaired skin integrity.

In an interview conducted by Inspector #687 with NP #110, they stated that when resident #004 was admitted to the home, the resident had no skin impairment but was at risk for impaired skin integrity as the resident required a specified skin care intervention to be implemented. The NP further stated that they had discussed with staff members and management that the home had to formulate strategies for them to prevent impaired skin integrity from developing.

In an interview conducted by Inspector #687 with the Acting DOC, they acknowledged that resident #004 had no skin impairment upon admission to the home. Regarding resident #004's skin impairments, in relation to the NP orders not

being processed in a timely manner, they stated that "The resident required assistance to [implement the skin care intervention]. When an MD or NP order was written, it should have been flagged for the registered staff and dealt with. That was not right!".

b) A complaint was received by the Director which outlined alleged neglect of care related to resident #004's fall incident.

During an interview conducted by Inspector #687 with PSW #107, they stated that on the day of the resident's fall, they were providing care to resident #004 and had left the resident to obtain a care product. The PSW further stated that when they had returned to the resident, they were found to have fallen. The PSW stated that they were regretful and remorseful of what had happened.

In a review of resident #004's electronic care plan in effect at the time of the incident, the care plan interventions included that the resident required two-staff for assistance when receiving the specified type of care being provided at the time of the fall.

In an interview with Registered Nurse (RN) #106, the RN verified they had responded to resident #004's fall incident, and that the resident had sustained injuries as a result the fall.

Inspector #687 conducted an interview with the Acting DOC. They stated that based on the home's internal investigation, the allegation of neglect by PSW #107 towards resident #004 was substantiated.

c) O. Reg. 79/10 defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth, that is made by anyone other than a resident"; and physical abuse as "the use of physical force by anyone other than a resident that causes physical injury or pain".

A CIS report was submitted to the Director as a result of an alleged incident of staff-to-resident abuse. The CIS report indicated that the Acting DOC received a call from the complainant stating that PSW #105 had been very rude to resident #006 and had thrown an object at them.

During an interview with Inspector #759, resident #006 indicated that a staff member threw the object at them.

Inspector #759 reviewed the home's investigation notes that related to this incident and identified a document that indicated that PSW #105 entered resident #006's room, picked up the object, and threw it towards resident #006. It further indicated that PSW #105 stated to the resident that they wished they would stop calling for staff all the time.

Inspector #759 reviewed PSW #105's employee file and identified a document which indicated that upon the outcome of the investigation, it was determined that PSW #105 had committed abuse to resident #006 as they had thrown the object at the resident. It further indicated that this incident was in violation of Extendicare's abuse and neglect policy.

Inspector #759 conducted an interview with the Acting DOC, where they confirmed that PSW #105 failed to comply with the zero tolerance of abuse policy and that the abuse was substantiated.

d) O. Reg. 79/10 defines sexual abuse as "any consensual or non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation that is directed towards a resident by a licensee or staff member".

A Critical Incident System (CIS) report was submitted to the Director as a result of an alleged incident of staff-to-resident sexual abuse. The CIS report indicated that PSW #109 had engaged in inappropriate sexual contact with resident #005.

Inspector #759 reviewed resident #005's electronic progress notes and identified a progress note written by RN #106. The note indicated that RN #106 spoke with resident #005, who indicated that PSW #109 had touched them inappropriately.

During an interview, RN #106 indicated to Inspector #759 that resident #005 reported to them what had happened, and that the RN immediately sent PSW #109 home as a result.

Inspector #759 reviewed the home's investigation notes related to the incident and identified that the allegation of PSW #109 sexual abuse toward resident #006 was

consistent with the investigation notes.

Inspector #759 conducted an interview with the Acting DOC. They confirmed that PSW #109 had not complied with the zero tolerance of abuse policy and that the allegation of sexual abuse was substantiated.

e) During an observation conducted by Inspector #687 on March 4, 2020, at 1430 hours, resident #011 was observed walking towards the nursing station. The resident smelled like they had been incontinent, and there was no staff member present along the hallway or at the nursing station at that time.

In an interview conducted by Inspector #687 with PSW #108, they informed the Inspector that they had provided care to resident #011 at 0830 hours on March 4, 2020, and were not able to provide care to the resident after that time as they were short-staffed and were working alone in the home unit that shift.

During an interview with RPN #112, the RPN stated that resident #011 required assistance for care, but PSW #108 was not able to provide the care required for the resident on March 4, 2020. The RPN further stated that there was only one PSW staff member in the home area for 44 residents and that it was clear neglect of care as the staff were unable to provide the care required for the resident at that time.

Inspector #687 interviewed RN #106 and verified that the third-floor home area was short-staffed during the day shift on March 4, 2020. The RN further stated that a unit meeting was conducted daily at 0930 hours with the ED, the Acting DOC, RAI Coordinator, Physiotherapy Assistant, and Unit Managers. The RN verified that the home's daily staffing level issues were discussed, and management was made aware.

In an interview with the Acting DOC, they stated that if a resident was required to have their continence care provided, a staff member, and generally the PSWs had to provide care. The Acting DOC further stated that "with regards to [resident #011], I would say that the care was not provided. I can't deny that. But I guess, that leads to neglect".

f) During an observation conducted by Inspector #687 on March 4, 2020, Inspector #687 heard an alarm in one resident's room at 1432 hours and noted there were no

staff members present along the hallway or at the nursing station at that time. The Inspector found resident #012 on the toilet and noted that their alarm had been triggered and rang for seven minutes before being responded to.

In an interview conducted by Inspector #687 with PSW #108, they stated that resident #012 required assistance for care, and required the alarm for their safety. The PSW further stated that they did not hear the alarm when it rang as they may have been attending to another resident along the opposite hallway.

During an interview with RPN #112, they stated that resident #012 required assistance for care, but PSW #108 was not able to provide the care required for the resident as they were short-staffed and there was only one PSW on the floor to care for 44 residents. The RPN further stated that it was clear neglect of care as they were unable to provide the care required for the resident at that time.

In an interview with the Acting DOC, they stated that, "This was awful! A staff member should have informed me and the Executive Director about this. Regarding resident #012, I would say that the care was not provided. I can't deny that. But I guess, that leads to neglect. I just wish that I knew that".

The decision to issue a CO was based on the severity of the issue, which was a level 3, indicating actual harm or actual risk. The scope of the issue was a level 3, indicating the issue was widespread. The home's compliance history related to the issue was a level 2, indicating previous non-compliance to a different subsection. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 05, 2020(A1)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 101. Dealing with complaints

Order / Ordre :

The licensee must comply with s. 101 of Ontario Regulation 79/10.

Specifically, the licensee must ensure that:

a) For every written or verbal complaint made to the licensee or staff member concerning the care of a resident or operation of the home:
- The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately.
- For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.
- A response shall be made to the person who made the complaint, indicating, what the licensee has done to resolve the complaint; or that the licensee believes the complaint to be unfounded and the reasons for the belief.

b) Except in the case of a verbal complaint that is able resolved within 24 hours of being received, a documented record is kept in the home that includes:
- The nature of each verbal or written complaint;
- The date the complaint was received;

- The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- The final resolution, if any;
- Every date on which any response was provided to the complainant and a description of the response; and
- Any response made in turn by the complainant.

c) The home's documented complaints record is reviewed and analyzed for trends at least quarterly, and:
- The results of the review and analysis are taken into account in determining what improvements are required in the home.
- A written record is kept of each review and of the improvements made in response.

Grounds / Motifs :

1. The licensee has failed to ensure that:
- For every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home, a response was made to the person who made the complaint, indicating what the licensee had done to resolve the complaint; or that the licensee believed the complaint to be unfounded and the reasons for the belief. [s. 101 (1)]
- A documented record was kept in the home that included, that nature of each complaint; the date the complaint was received; the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; the final resolution, if any; every date on which any response was provided to the complainant and a description of the response; and any response made in turn by the complainant. [s. 101 (2)]
- The documented complaints record was reviewed and analyzed for trends at least quarterly; the results of the review and analysis were taken into account in determining what improvements were required in the home; and a written record was kept of each review and of the improvements made in response. [s. 101 (3)]

a) A written complaint was received by the Acting DOC regarding the care of resident #001. The complaint alleged that when the complainant visited the home following a fall of resident #001, a specified falls prevention intervention was not working. The complainant also alleged that this was the third time during that week the falls prevention intervention had not been working when they visited the home. The

complainant alleged that when they had presented the issue to staff, staff had given the complainant "a myriad of excuses", and indicated that staff did not know how to rectify the issue.

The home's policy titled "Complaints and Customer Service – RC-09-01-04", last updated June 2019, stated that the ED, Department Manager, or designate must "provide a written response at conclusion of investigation" to include "what the home has done to resolve the complaint" or "if the complaint is unfounded, the reasons why this conclusion was reached". The policy also stated that "each contact with the complainant should be recorded on the Contact Log" by the person making the contact".

The Acting DOC wrote a response letter to the complainant, which stated that staff were alerted to resident #001's fall by the sound of the specified falls prevention intervention. The response letter made no mention that anything had been done to resolve the complainant's concerns, or that they believed the complaint to be unfounded and the reasons for that belief, with regard to:
- The allegation that the falls prevention intervention had not been working when the complainant had visited the home, following resident #001's fall, and two other times that same week; and
- The allegation that staff were unable to rectify the issue of the falls prevention intervention not working.

Inspector #757 conducted a record review of resident #001's electronic health records. A progress note completed by RPN #112, stated they had "Heard a loud bang coming from the resident's room. Went into the [their] room and found [they had fallen]". The post-fall assessment was also reviewed. Neither the progress notes, or the post-fall assessment, made any mention of the specified falls prevention intervention alerting staff to the fall.

During an interview with the Acting DOC, Inspector #757 requested that they provide all of their documentation related to their investigation into the complaint. The Acting DOC stated that they had no documentation related to their investigation. They stated that during their investigation they "would have checked the records, [falls interventions], and made sure that things were in place" and "would have spoken to the charge nurse and the RPN working that day"; however, they were unable to name the charge nurse they had spoken to, and identified the RPN working that day

only after reading resident #001's electronic progress notes during the interview.

During an interview with RPN #112, they stated that they had initially responded to resident #001 following their fall on January 2, 2020. The RPN indicated that when they responded, the falls prevention intervention was in place; however, the intervention was not making a sound when they responded to the fall.

Inspector #757 conducted an interview with the Acting DOC, where they were asked how they were able to determine that the falls prevention intervention was functioning at the time of resident #001's fall, and why the complainant had been told this. They responded by saying "I'm just telling you what was relayed to me" and "I responded to [them] as I was told to" by the home's previous Executive Director. They confirmed that the letter of response had not included either what the home had done to resolve the complainant's specific complaints; or that they believed the complaints to be unfounded, and the reasons for that belief.

b) The home received a verbal complaint regarding a missing personal item belonging to resident #016.

The home's complaint investigation form noted that the home spoke with the complainant regarding the complaint; and investigated the complaint two days later; however, the form included no indication of a response ever being made to the complainant following the investigation. The form also stated that the personal item was unable to be located after a search of the resident's room, and following-up with housekeeping and laundry, but indicated that the complaint was unfounded despite the personal item not ever being located.

During an interview with the ED, they confirmed that the complaint investigation form made no mention of any response made to the complainant to indicate what was done to resolve the complaint, or to indicate that the complaint was unfounded and the reason for that belief.

c) The home's policy titled "Complaints and Customer Service – RC-09-01-04", last updated June 2019, stated that the ED, Department Manager, or designate must "Initiate an investigation into the circumstances leading to the complaint within 24 hours"; "Take notes of all interview questions, observations, and other actions related to the investigation"; "When possible, witness questions and statements should be

written by the witness, dated and signed"; and "keep all materials related to the investigation together in one file for future retrieval and quality improvement auditing purposes".

A written complaint was received by the Acting DOC regarding the care of resident #001. The complaint alleged that when the complainant visited the home following a fall of resident #001, a specified falls prevention intervention was not working. The complainant also alleged that this was the third time during that week the falls prevention intervention had not been working when they visited the home. The complainant alleged that when they had presented the issue to staff, staff had given the complainant "a myriad of excuses", and indicated that staff did not know how to rectify the issue.

The Inspector reviewed the home's complaints binder, which contained only the e-mail correspondence between the home and the complainant, and included no other documentation.

During an interview with the Acting DOC, Inspector #757 requested that they provide their documentation related to their investigation into the complaint. The Acting DOC confirmed that they had completed no documentation related to their investigation or resolution of the complaint, and only had their e-mail correspondence with the complainant.

d) The home received a verbal complaint regarding a missing personal item belonging to resident #016.

Inspector #757 reviewed the home's complaint investigation form related to the complaint. The form included a brief description of the complaint, and a summary of the investigation and action taken with associated timeframes. However, the form did not indicate who the complaint was received from, indicating only their relation to the resident.

The complaint investigation form noted that the home spoke with the complainant to collect information regarding the complaint, and investigated the complaint two days later; however, the form makes no mention of a response ever being made to the complainant following their investigation, and the space for "completion date" was left blank. The "Contact Form" included in the complaint investigation form indicated that

only "Laundry" and "Kitchen" were contacted following the home's initial call with the complainant.

The complaint investigation form noted that the personal item was unable to be located after a search of the resident's room, and after the home followed up with housekeeping and laundry staff, but indicated that the complaint was unfounded despite the personal item not ever being located.

During an interview with the ED, they confirmed that the report did not include the complainant's name; every date a response was provided to the complainant, and a description of the response; and any response made in turn by the complainant.

e) The home received a verbal complaint regarding the care of resident #017, stating that the resident's specified skin care intervention had been turned off when they visited the home and that the resident's care equipment was uncomfortable. The complaint also included concerns regarding the maintenance and housekeeping of the home.

Inspector #757 reviewed the home's complaint investigation form regarding this complaint. The form included a brief description of the complaint, a summary of the investigation and actions taken with associated time frames. The form indicated that the complaint was founded, and that the complainant was contacted following the initial investigation. However, the form also indicated that follow-up action was required to resolve the complaint regarding the concerns around resident #017's care equipment, and that a separate person would have to be contacted regarding that portion of the complaint. Under the heading of "Attempts to Contact", the form indicated that one attempt to contact the other person was made and a message was left. The form indicated no further attempts at contact, and the space on the investigation form indicating "Date Completed" was blank.

During an interview with the ED, they confirmed that the final resolution of the complaint was not included in the documentation related to all the concerns indicated in the complaint.

f) During an interview with the Acting DOC, they stated that the home did not have records or a system to review and analyze complaint documentation in order to determine what improvements may need to be made to the home.

The ED provided Inspector #757 with a document titled "Complaints Tracker Extendicare 2019". The document included sheets for monthly tracking of all of the complaints received by the home, followed by a quarterly "Complaint Action Plan" to assess the effectiveness of the previous quarter's action plan, and included an analysis of complaint data for the immediate past quarter, actions to be taken going forward, and identified trends. The Inspector reviewed the home's Complaint Action Plans for the quarterly periods of April to June 2019; July to September 2019; and October to December 2019, and identified that none of the analyses had any completed documentation.

During an interview with the ED, they confirmed that the document had not been completed, and that the complaint record had not been reviewed and analyzed for trends at least quarterly.

The decision to issue a CO was based on the scope of the issue, which was a level 3, indicating the issue was widespread. The severity of the issue was a level 1, indicating no harm. The home's compliance history related to this issue was a level 3, indicating previous non-compliance to the same subsection:
- VPC issued December 9, 2019, in inspection report #2019_633577_0032 [s. 101 (1)];
- VPC issued September 24, 2019, in inspection report #2019_624196_0022 [s. 101 (1)];
- VPC issued May 13, 2019, in inspection report #2019_624196_0010 [s. 101 (1)];
- VPC issued December 9, 2019, in inspection report #2019_633577_0032 [s. 101 (2)];
- VPC issued May 13, 2019, in inspection report #2019_624196_0010 [s. 101 (2)]. (757)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 05, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

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

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

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

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

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

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

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

Issued on this 7 th day of January, 2021 (A5)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DAVID SCHAEFER (757) - (A5)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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Ordre(s) de l'inspecteur

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