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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 21, 2020	2019_751649_0023	019901-19, 019962-19	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Cheltenham Care Community
5935 Bathurst Street NORTH YORK ON M2R 1Y8

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

JULIEANN HING (649)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): December 3, 4, 5, 6, 9, 10, 11, off-site 13, 17, 20, 23, and 24, 2019.

Log #019962-19 is related to pest control, lingering odors, mobility devices, and housekeeping and log #019901-19 is related to continence care and bowel management, housekeeping, and plan of care.

During the course of the inspection, the inspector(s) spoke with the executive director (ED), director of care (DOC), assistant director of care (ADOC), director of environmental services (DES), registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), maintenance staff, housekeeping staff, residents and family members.

During the course of the inspection the inspector reviewed residents' health records, staffing schedules, job routines, housekeeping and maintenance audits, Abell service logs, scheduled maintenance logs, and conducted observations.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Infection Prevention and Control
Personal Support Services

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

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

WN #1: The Licensee has failed to comply with 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 are kept clean and sanitary.

A complaint was reported to the Ministry of Long-Term Care (MLTC), expressing concerns about the home's cleanliness.

During an interview with the complainant, they alleged upon resident #001's admission that there were dirty areas on the floor, blackened areas around the sink, and concern of a lingering odor all of which were identified in the resident's room. The complainant provided videos and photographs of their concerns.

During a tour of the home on December 9 and 10, 2019, the following observations were identified by Inspector #649. These concerns were brought to the DES attention during a brief tour on December 11, 2019:
Residents' rooms:
-dirty areas on floor along baseboards in bedroom and washroom and between creases of vinyl tiles in bedroom; dirty and loose window coverings; dirty metal strip (threshold) at bathroom entrance; blackened area around faucet and around the sink drain hole; black spots on an identified night stand; dirty black line observed on the bottom portion of an identified bedroom door; blackened area on floor behind the toilet tank in washroom; thick accumulation of dirt in the window grooves; dirty privacy curtain in an identified resident's room; black mark along the wall in an identified bedroom; dirty sink faucet; dirty areas around identified equipment and on walls in washroom in an identified room; dirty and peeling caulking around base of toilet; and dirty area around base of toilet.

Other areas of concern related to cleanliness were identified during the inspector's tour of

the home are as follows:
-thick accumulation of dust on the vent across from identified residents' rooms
-thick accumulation of dust on air flow vents on shower doors
-dirty areas on the floor along baseboards in hallways on residents' home areas
-dirty spots on the ceiling on an identified home area across from small lounge
-thick accumulation of dirt in the grooves on steam table in an identified dining room
-dirty areas on the floor along baseboards in an identified dining room
-accumulation of dirt under the sink in an identified dining room.

In an interview with housekeeping staff #111, they explained they are responsible for mopping the floors in residents' rooms and deep cleaning is completed by a different staff doing special projects (SP). According to the housekeeping staff they and the SP staff are responsible for scraping floors to remove juice and coffee stains. The housekeeping staff further explained that when the home was short the housekeeping staff the SP was pulled to cover the housekeeping shift, therefore leaving no replacement for the SP. They further explained that the home had been short the full-time SP staff since that staff had been off work due to medical reasons.

In an interview with the DES #125, they acknowledged based on the videos provided by the inspector of resident #001's room at admission, that there was an accumulation of dirt on the floor behind the resident's bedroom door. According to the DES the cleaning of residents' floors along baseboards in their rooms was the responsibility of the housekeeping staff and not the SP. The ED told the inspector that since the full-time SP staff was off work for medical reasons, they did not have a regular SP staff, and that the home had been short two to three weeks or even up to a month. During a tour of the home they acknowledged the above mentioned concerns, and stated that the home needs to be brought up to standard immediately.

In an interview with ED #129, they acknowledged that they were not aware to the extent of the concerns and explained that the home is implementing changes including audits, new job descriptions, deep cleaning, and other protocols to ensure an improvement in the home's cleanliness. [s. 15. (2) (a)]

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

During a tour of the home on December 9 and 10, 2019, the following observations were identified by Inspector #649. These concerns were brought to the DES attention during a

brief tour on December 11, 2019:
Residents' rooms:
-chipped and cracked ledges in washrooms; loose and raised metal strip (threshold) at a bathroom entrance - missing screws on both ends; cracked and missing vinyl tiles; cover broken and wires exposed on electrical box on the wall between the resident's beds; loose drawers on night stands and closet; chipped night stands and closet, cracked and raised drywall below towel bar in washroom; loose panel on wall outside washroom; cracked, chipped, and rusting areas on door frames; gap between the floor and drywall; rust spot on the floor under the sink in washroom; holes in the drywall; rust spots on towel bars in washrooms; loose baseboards in washrooms and bedroom; chipped sink in washroom; rust in sink and around drain holes in washroom; chipped laminate on sinks; rust spots on drain pipes in bedroom and washroom and under the sink in washrooms; cracked sink faucet in bedroom; chipped drywall in washroom; several chips on the sink in washroom; broken and separated laminate on the sink counter top in washroom; and loose and chipped railing outside an identified resident's room.

Other maintenance concerns identified during a tour of the home are as follows:
-cracked, chipped, and rusting areas on baseboards in hallways, door frames at room entrances throughout the home and loose railing on an identified hallway.

According to the Abell service logs the following recommendations were identified:
October 10, 2019 – Minor pest activity found on an identified home area behind fridge and under sink. Shelf under sink needs to be replace (wet - small fly activity).
November 15, 2019 – Treated identified home area for pest, activity found under the refrigerator. Floor under the sink needs to be replaced

In an interview with the full-time maintenance staff #110, they acknowledged they are responsible for any maintenance related work in the home. According to the maintenance staff the DES will assess a resident's room and enter the required work into maintenance care for them to complete. They told the inspector they had completed repairs on the sink in the resident #001's room prior to their admission due to a leak.

In an interview with the DES, they told the inspector that based on the video footage and photographs, the sink in resident #001's room was rusted. They explained that the brown marks on the sink's counter top in the resident's room was a urine stain. The DES acknowledged that one of the drawers on resident #001's closet was stuck and only repaired after resident #001 had moved in the room. The DES confirmed that the above mentioned recommendations from Abell had not been completed by the home as of the

time of this interview. During a tour of the home they acknowledged the maintenance issues mentioned above observed throughout the home was unacceptable.

ED #129 was made aware of the identified concerns and explained in an interview that the home is taking measures to address and fix the identified issues. [s. 15. (2) (c)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
3. Communication abilities, including hearing and language. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001’s plan of care must be based on, at a minimum interdisciplinary assessment of communication abilities, including hearing and language.

A complaint was brought to the MLTC regarding resident #001's incontinence care.

In an interview with resident #001 using a translator, they expressed concern that the staff in the home did not understand what they said.

A review of the resident’s care plan in point click care (PCC) did not indicate that they spoke another language. The resident`s care plan indicated they had difficulty with communicating but failed to identify effective ways on how to best communicate with the resident. Further review indicated that the resident had a deficit affecting their communication but no instructions on how to communicate effectively with the resident was identified.

In separate interviews with PSWs #100 and #103, they told the inspector they did not speak the same language as the resident. According to PSW #100, resident #001 did not speak much English. PSW #103 told the inspector that they could not speak the same language as the resident and only understood a few simple words in the resident's language to provide care. According to PSW #103 the resident did not speak a single word of English and used sign language to communicate with resident #001 to provide care.

In an interview with RN #108 ,they acknowledged that resident #001’s plan of care did not indicate that the resident spoke another language. They further explained they would expect to see in the resident’s plan of care, cue cards with simple words so that staff are aware of how to communicate with the resident.

In an interview with ADOC #113 they acknowledged they were not able to see at the time of the interview if the resident’s plan of care indicated that they spoke another language. They explained to the inspector that they would expect to see in a resident’s plan of care any deficiencies or problems with communication and indicate alternative methods of communication if there is a language barrier. [s. 26. (3) 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 a plan of care must be based on, at a minimum interdisciplinary assessment of communication abilities, including hearing and language, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(e) continence care products are not used as an alternative to providing assistance to a person to toilet; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #001 who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

A complaint was brought to the MLTC regarding resident #001's incontinence care.

According to the resident’s initial bladder and bowel continence assessment, they were incontinent of bladder and frequently incontinent of bowels and wore an incontinent brief.

A review of the resident’s written care plan in PCC indicated under bladder and bowel that the resident was incontinent related to physical limitation and to see the Tena inventory list for the product. The resident’s written care plan did not indicate an

individualized plan on how to manage the resident’s bladder and bowel habits in terms of the resident's assessed continence care needs. Further review of the resident's plan of care did not indicate an individualized continence plan.

In an interview with RN #108, they told the inspector that they would expect to see in an individualized plan of care, the incontinence level, the product type, and the resident’s preferences. The RN further explained the resident’s preferences would include if they would like to use the commode so that PSWs are aware. According to the RN they were told by their corporate office not to incorporate these things in the residents’ written care plan. The RN acknowledged that resident #001’s plan of care did not indicate to staff if to toilet them or the method on how the resident should be toileted.

In an interview with ADOC #113, they acknowledged that resident #001's plan of care was not individualized and would expect to see in an individualized plan of care, the times when the resident would be offered the toilet or changed in bed if they were not able to sit on the toilet.

Based on the above staff interviews resident #001’s plan of care was not individualized to promote the management of the resident’s bowel and bladder continence assessed care needs. [s. 51. (2) (b)]

2. The licensee has failed to ensure that continence care products were not used as an alternative to providing assistance to resident #001 to toilet.

According to resident #001’s initial bladder and bowel continence assessment, they were incontinent of bladder and frequently incontinent of bowels and wore an incontinent brief.

A review of the resident’s written care plan in PCC indicated under bladder and bowel that the resident was incontinent related to physical limitation and to see the Tena inventory list for the product.

In an interview with PSW #103 who has been working with the resident on the evening shift told the inspector that the resident has their bowel movements in bed. According to PSW #103 the resident would tell them when they would like to have a bowel movement and they would ask them to go on their side and have the bowel movement in bed. They stated if they transferred the resident with the mechanical lift to the commode and back to bed they would run out of time.

In an interview with RN #108, they acknowledged that if the resident is able to express when they would like to have a bowel movement, they should be transferred to the commode and placed on the toilet. According to the RN, they spoke with several PSWs who told them that resident #001 is able to express when they would like to have a bowel movement and is being transferred to the commode over the toilet.

In an interview with ADOC #113 in response to the home's expectation when resident #001 was told by PSW #103 to go on their side and have a bowel movement, they explained that if the resident requested to go to the toilet and there were no contradictions the resident should be placed on the toilet to have a bowel movement. [s. 51. (2) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented and that continence care products are not used as an alternative to providing assistance to a person to toilet, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that no resident who requires assistance with eating or drinking was served a meal until someone was available to provide the assistance required by resident #003.

While conducting observations of residents' home area on December 11, 2019, at approximately 0940 hours, with DOC #114, resident #003 was observed lying in bed, and a breakfast tray was observed on the beside table beside their bed. The DOC immediately inquired with staff to have the tray removed from the resident room.

Resident #003 was not interviewable due to cognitive decline.

A review of resident #003's care plan under eating indicated that the resident required one staff total assistance for eating.

In a brief interview with PSW #115 at the time of the observation, they told the inspector that resident #003 was not able to eat on their own. According to PSW #115, one PSW was responsible for providing the resident trays in their rooms and identified that staff as PSW #128. They acknowledged that the tray service should only be provided to resident #003 when there is someone available to assist them.

Several attempts were made to contact PSW #128 for an interview without success.

In an interview with RN #127 and in a follow-up interview with DOC #114, they both acknowledged that according to the resident's care plan they required total assistance with their meals. They acknowledged that any resident who required assistance with meals should only have their meals brought to them when there is someone available to provide them with the assistance they require. [s. 73. (2) (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 no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff participated in the implementation of the infection prevention and control program.

While conducting a tour of the home on October 10, 2019, the following observations were made by Inspector #649:
-shared washrooms - unlabeled urinals, one of the urinals had a blackened area around the opening, and unlabeled urine hats.

As a result of not having each urinal or urine hat labelled with the resident's name in a shared washroom increases the risk for cross contamination.

The above mentioned observations were shown to DOC #114.

In an interview with RN #127, they acknowledged all urinals and hats in shared washrooms must be labelled with the resident's name.

In an interview with DOC #114, who is the co-lead for the home’s infection prevention and control (IPAC) program acknowledged that the staff did not fully participate in the implementation of the home’s IPAC program, and spoke with the co-lead (RN #108) to have all the urinals and hats replaced and labeled with the resident's name. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

Issued on this 4th day of February, 2020

[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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JULIEANN HING (649)
Inspection No. / No de l'inspection :	2019_751649_0023
Log No. / No de registre :	019901-19, 019962-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jan 21, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Cheltenham Care Community 5935 Bathurst Street, NORTH YORK, ON, M2R-1Y8
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Gillingham

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 Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

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 : 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. 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 be compliant with s. 15. (2) (a) and (c).

Specifically, the licensee must:

1. Ensure all areas of the home are kept clean and sanitary including residents' rooms, washrooms, residents' room entrances, hallways, and areas along baseboards.
2. Ensure all areas of the home are kept in a good state of repair including residents' furnishings, towel bars, skin faucets, and ledges in residents' rooms, washrooms, residents' room entrances, and hallways.
3. Documentation of audits of resident's home areas to ensure the home is kept clean and sanitary and in a good state of repair. A record of the audits completed must be maintained that include resident's rooms, date of the audit, and the name of the staff who completed the audit, and any concerns identified and what action was taken.
4. Implement a process to ensure prior to a new admission their furnishings and equipment are in a good state of repair, and the room and washroom are clean and sanitary. A record must be maintained of the room inspection completed prior to new admission move in, including the room number, date of the room inspection, and the name of the staff who completed the inspection including any concerns identified and what action was taken.

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 are kept clean and sanitary.

A complaint was reported to the Ministry of Long-Term Care (MLTC), expressing concerns about the home's cleanliness.

During an interview with the complainant, they alleged upon resident #001's admission that there were dirty areas on the floor, blackened areas around the sink, and concern of a lingering odor all of which were identified in the resident's room. The complainant provided videos and photographs of their concerns.

During a tour of the home on December 9 and 10, 2019, the following observations were identified by Inspector #649. These concerns were brought to the DES attention during a brief tour on December 11, 2019:
Residents' rooms:
-dirty areas on floor along baseboards in bedroom and washroom and between creases of vinyl tiles in bedroom; dirty and loose window coverings; dirty metal strip (threshold) at bathroom entrance; blackened area around faucet and around the sink drain hole; black spots on an identified night stand; dirty black line observed on the bottom portion of an identified bedroom door; blackened area on floor behind the toilet tank in washroom; thick accumulation of dirt in the window grooves; dirty privacy curtain in an identified resident's room; black mark along the wall in an identified bedroom; dirty sink faucet; dirty areas around identified equipment and on walls in washroom in an identified room; dirty and peeling caulking around base of toilet; and dirty area around base of toilet.

Other areas of concern related to cleanliness were identified during the inspector's tour of the home are as follows:
-thick accumulation of dust on the vent across from identified residents' rooms
-thick accumulation of dust on air flow vents on shower doors
-dirty areas on the floor along baseboards in hallways on residents' home areas
-dirty spots on the ceiling on an identified home area across from small lounge
-thick accumulation of dirt in the grooves on steam table in an identified dining room
-dirty areas on the floor along baseboards in an identified dining room
-accumulation of dirt under the sink in an identified dining room.

In an interview with housekeeping staff #111, they explained they are responsible for mopping the floors in residents' rooms and deep cleaning is completed by a different staff doing special projects (SP). According to the housekeeping staff they and the SP staff are responsible for scraping floors to remove juice and coffee stains. The housekeeping staff further explained that when the home was short the housekeeping staff the SP was pulled to cover the housekeeping shift, therefore leaving no replacement for the SP. They further explained that the home had been short the full-time SP staff since that staff had been off work due to medical reasons.

In an interview with the DES #125, they acknowledged based on the videos provided by the inspector of resident #001's room at admission, that there was an accumulation of dirt on the floor behind the resident's bedroom door. According to the DES the cleaning of residents' floors along baseboards in their rooms was the responsibility of the housekeeping staff and not the SP. The ED told the inspector that since the full-time SP staff was off work for medical reasons, they did not have a regular SP staff, and that the home had been short two to three weeks or even up to a month. During a tour of the home they acknowledged the above mentioned concerns, and stated that the home needs to be brought up to standard immediately.

In an interview with ED #129, they acknowledged that they were not aware to the extent of the concerns and explained that the home is implementing changes including audits, new job descriptions, deep cleaning, and other protocols to ensure an improvement in the home's cleanliness. (649)

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

During a tour of the home on December 9 and 10, 2019, the following observations were identified by Inspector #649. These concerns were brought to the DES attention during a brief tour on December 11, 2019:
Residents' rooms:
-chipped and cracked ledges in washrooms; loose and raised metal strip (threshold) at a bathroom entrance - missing screws on both ends; cracked and missing vinyl tiles; cover broken and wires exposed on electrical box on the wall between the resident's beds; loose drawers on night stands and closet; chipped

night stands and closet, cracked and raised drywall below towel bar in washroom; loose panel on wall outside washroom; cracked, chipped, and rusting areas on door frames; gap between the floor and drywall; rust spot on the floor under the sink in washroom; holes in the drywall; rust spots on towel bars in washrooms; loose baseboards in washrooms and bedroom; chipped sink in washroom; rust in sink and around drain holes in washroom; chipped laminate on sinks; rust spots on drain pipes in bedroom and washroom and under the sink in washrooms; cracked sink faucet in bedroom; chipped drywall in washroom; several chips on the sink in washroom; broken and separated laminate on the sink counter top in washroom; and loose and chipped railing outside an identified resident's room.

Other maintenance concerns identified during a tour of the home are as follows:
-cracked, chipped, and rusting areas on baseboards in hallways, door frames at room entrances throughout the home and loose railing on an identified hallway.

According to the Abell service logs the following recommendations were identified:
October 10, 2019 – Minor pest activity found on an identified home area behind fridge and under sink. Shelf under sink needs to be replace (wet - small fly activity).
November 15, 2019 – Treated identified home area for pest, activity found under the refrigerator. Floor under the sink needs to be replaced

In an interview with the full-time maintenance staff #110, they acknowledged they are responsible for any maintenance related work in the home. According to the maintenance staff the DES will assess a resident's room and enter the required work into maintenance care for them to complete. They told the inspector they had completed repairs on the sink in the resident #001's room prior to their admission due to a leak.

In an interview with the DES, they told the inspector that based on the video footage and photographs, the sink in resident #001's room was rusted. They explained that the brown marks on the sink's counter top in the resident's room was a urine stain. The DES acknowledged that one of the drawers on resident #001's closet was stuck and only repaired after resident #001 had moved in the room. The DES confirmed that the above mentioned recommendations from

Abell had not been completed by the home as of the time of this interview. During a tour of the home they acknowledged the maintenance issues mentioned above observed throughout the home was unacceptable.

ED #129 was made aware of the identified concerns and explained in an interview that the home is taking measures to address and fix the identified issues.

The severity of this non-compliance was identified as minimal harm, the scope was identified as widespread. Review of the home's compliance history revealed unrelated non-compliance. Due to the scope being widespread a compliance order (CO) is warranted. (649)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jun 02, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 21st day of January, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : JulieAnn Hing

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