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

London Service Area Office
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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
Jul 31, 2020	2019_563670_0046 (A2)	023114-19	Complaint

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Tecumseh
2475 St. Alphonse Street TECUMSEH ON N8N 2X2

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

Amended by DEBRA CHURCHER (670) - (A2)

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

Amendment Reason: CDD to be extended for order #002 from inspection #2019_563670_0046 to October 31, 2020 as per Director's direction related to Pandemic Emergency Order related to visitation restrictions.

Issued on this 31st day of July, 2020 (A2)

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 31, 2020	2019_563670_0046 (A2)	023114-19	Complaint

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

Extendicare Tecumseh
2475 St. Alphonse Street TECUMSEH ON N8N 2X2

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

Amended by DEBRA CHURCHER (670) - (A2)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): December 9, 11, 12 and 16, 2019.

The purpose of this inspection was to inspect a complaint Log# 023114-19 related to food quality, staffing, maintenance and housekeeping in the home.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Care, the Nutrition Manager, the Housekeeping Manager, the acting Maintenance Manager, one Scheduling Clerk, one Registered Nurse, three Personal Support Workers, one Housekeeper and one Dietary Aide.

During the course of this inspection the inspectors observed the overall cleanliness and maintenance of the home, observed two meal services, observed the provision of care, observed staff to resident interactions, reviewed relevant clinical records, reviewed relevant internal documentation and reviewed relevant polices and procedures.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dining Observation
Food Quality
Safe and Secure Home
Sufficient Staffing

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

3 WN(s)
2 VPC(s)
2 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 kept clean and sanitary.

The Ministry of Long-Term Care received a complaint IL-72634-LO on December 5, 2019, related to concerns regarding the cleanliness of the home.

On December 12, 2019, a tour of the facility was conducted by inspector #670 and photos were taken.
Riverside Unit
-Noted multiple visibly soiled areas on multiple wall surfaces.
-Noted the bumper baseboards to be coated in a large amount of dust and debris.
-Noted the patio door across from a specific room to be excessively soiled and large amount of dust and cobwebs noted.
-Noted multiple chairs and loveseats that were visibly stained.

Lakeside Unit
-Noted the patio door outside the Behavior Support office to be very soiled and noted cob webs and large amount of dust.
-Noted cobwebs dust and hair on the floor and on baseboards entering the dining room on the office side, outside the documentation room, and outside room a specific room.
-Noted soiled walls in spa room number one, outside a specific room and on the wall across from the nurses station.
-Noted multiple soiled love seats and chairs.

Oldcastle Unit
-Noted multiple chairs and love seats that were stained.

-Noted the patio door outside of a specific room to be soiled and have multiple cobwebs.
-Noted the wall outside two specific rooms and the wall outside the dining room to be visibly soiled.

Livingstone Unit
-Noted multiple chairs and loveseats to be stained.
-Noted the wall in spa 2 and the wall across from the nurse's station to be visibly soiled.
-Noted the patio door across from the activity room to be heavily soiled and have cobwebs and the rail across the patio door was also soiled.

On December 13, 2019, Inspector #670 and Housekeeping Manager (HM) #104 toured the Riverside unit and reviewed collected photographs. HM #104 acknowledged that the home was not clean. HM #104 stated that it was the expectation that the home and the furnishings would be kept clean and this was not being done to the expected standards.

On December 13, 2019, during an interview with Inspector #670 the Director of Care (DOC) #102 stated that expectation was that the home would be kept clean and sanitary including walls and furnishings and acknowledged that this expectation was not being met.

On December 12, 2019, Inspector #630 observed the dining rooms for all four resident home areas and identified the following:
- four out of four dining rooms had dirt and splatter throughout the room on the walls and hand rails;
- one out of four dining rooms had dirt build-up in the corner going into the room;
- four out of four dining rooms had dirt splatter on the blinds;
- two out of four dining rooms had black feeding assistance stool with dirt and spills on the base.

On December 13, 2019, Inspector #630 observed the serveries for all four resident home areas and identified the following:
- four out of four serveries had dirt and splatter throughout the room on the walls, front of cupboards and/or drawers;
- one out of four serveries had splatter and debris in the microwave;
- one out of four serveries had a food service cart with dirt and debris;
- the Riverside servery had dust build-up on the ceiling vent.

On December 13, 2019, Nutrition Manager (NM) #101 said the dietary aides were responsible for cleaning some of the areas in the serveries and dining rooms and the housekeeping staff were responsible for other cleaning tasks. Inspector #630 reviewed pictures taken of the serveries with NM #101 and they said that this did not meet the expectations in the home regarding cleanliness. Inspector #630, NM #101 and Administrator #107 then observed the Riverside servery and dining room and they said that these areas did not meet the expectations of the home in terms of cleanliness.

The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary. [s. 15. (2) (a)]

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

The Ministry of Long-Term Care received a complaint IL-72634-LO on a specific date, related to concerns regarding the maintenance of the home.

On December 12, 2019, a tour of the facility was conducted by inspector #670 and photos were taken.
Riverside Unit
-Noted missing flooring and damaged door jamb outside of clean utility room.
-Noted damaged blinds in the dining room with part of the blind laying on the window sill.
-Noted black duct tape that was peeling and lifted on the floor to the entrances of five specific rooms.
-Noted the main spa room to have damaged cabinets and damaged walls.
-Spa number two was noted to be out of service.
-Noted black tape to the dining room floor.

Lakeside Unit
-Noted the cabinets in spa number one to be damaged.
-Noted damaged baseboard outside a specific room.
-Noted damaged walls and base boards in spa room one, and outside of two specific rooms.

Oldcastle Unit
-Noted black tape that was peeling and lifting on the floor entering two specific

rooms.
-Noted the wall outside a specific room to be damaged.
-Noted the wall and cabinets in spa number one to be damaged.

Livingstone Unit
-Noted the wall in spa number two to be damaged.
-Noted the cabinets in spa room number one to be damaged.
-Noted the wall to be damaged across from the Nurses station.
-Noted black tape that was peeling and lifting to the entry way of a specific room.
-Noted cracked and lifting tiles in two specific rooms.
-Noted broken and missing hand rail with the ends covered in tape on the wall entering the dining room.
Inspector #670 observed multiple areas of broken rubber baseboards on all units.

On December 13, 2019, an interview was conducted with acting Maintenance Manager (MM) #103 by inspector #670. MM #103 stated that they had been hired part time in February 2018 however due to budgetary issues they did not receive any regular hours. Stated that there was a plan for them to come in to do repair on walls and rubber baseboards however the regular Maintenance Manager went off on a medical leave and they have been the acting Maintenance Manager since the beginning of November 2019. MM #103 acknowledged that they were aware of the multiple areas of damage in the home. MM #103 stated that the process in the home was for staff to document any concerns in the maintenance book at each nurse's stations and they would check the books every morning and address any concerns. MM #103 stated that this process does not always happen. MM #103 stated that the black tape on the floors that was peeling and lifting was a safety concern.

On December 13, 2019, an interview was conducted with Director of Care (DOC) #102 by Inspector #670. DOC #102 stated that expectation was that the home would be maintained in a safe condition and in a good state of repair and acknowledged that this expectation was not being met.

On December 12, 2019, Inspector #630 observed the serveries and dining rooms for all four resident home areas and identified the following:
- four out of four dining rooms had chipped paint throughout the room on the walls;
- two out of four dining rooms had food service carts with corners taped with duct tape which was peeling off;

- one out of four dining rooms had a damaged area on the floor covered with duct tape:
- one out of four dining rooms had damaged baseboards.

On December 13, 2019, Inspector #630 observed the serveries for all four resident home areas and identified the following:
- two out of four serveries had damaged walls;
- two out of four serveries had damaged baseboards;
- one out of four serveries had a hole in the floor by the doorway;
- two out of four serveries had damaged counter tops;
- two out of four serveries had damaged food services carts which were taped in areas with duct tape.

On December 13, 2019, Inspector #630 observed the doorway leading from the home's lobby area to the corridor of the main kitchen had two holes on the door frame on the right side.

On December 13, 2019, Nutrition Manager (NM) #101 said there was a process in place for the nutrition staff to notify the maintenance department when there was a concern in the serveries or dining rooms. NM #101 said that they also looked for maintenance concerns when doing audits and had identified some concerns with the condition of the floor in the Riverside servery on December 12, 2019, which they were going to report to the maintenance department. Inspector #630 reviewed pictures taken of the serveries and dining rooms with NM #101 and they said that this did not meet the expectations in the home regarding the state of repair. Inspector #630, NM #101 and Administrator #107 then observed the Riverside servery and dining room and they said that these areas did not meet the expectations of the home in terms of the state of repair.

The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure policies and procedures included in the required Dietary Service and Hydration Program were complied with regarding the state of repair of dishware used for residents' meal service.

LTCHA s.11(1)(a) requires an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents

O. Reg. 79/10, s. 68(2) requires the licensee to ensure that the program includes the development and implementation of policies and procedures related to dietary services.

Specifically, staff did not comply with the policy and procedure "Meal Service and Dining Experience" March 2019, which Nutrition Manager (NM) #101 stated was

part of the home's nutrition care and dietary services program. This policy stated "chipped, cracked china or glasses and any china that has lost its glaze should be removed and the Dietary Department Lead notified."

On December 11, 2019, a family member for residents #001 and #002 expressed concerns regarding the state of repair of plates used in the home. They emailed inspector #670 a photograph of a lipped plate used in the home which was stained and scratched.

On December 13, 2019, resident #003 reported to Inspector #630 that they found some of the dishes used in the home for meal service were chipped and broken and the staff did not remove them from use when they should.

On December 13, 2019, Inspector #630 observed plastic lipped plates and plastic dessert bowls in the serveries and used for meal service which were stained and scratched.

On December 13, 2019, Nutrition Manager (NM) #101 said it was the expectation in the home that all plates and bowls used as part of meal service would be in a good state of repair. NM #101 said they were aware that there were lipped plates and bowls that were being used which were scratched an stained. Inspector #630 reviewed pictures taken of the lipped plates and bowls in the home and NM #101 said these did not meet the expected standards in the home. NM #101 said that they did not think the home had a specific policy regarding the expected condition of dishware, but the "Meal Service and Dining Experience" policy would apply to all plates and bowls and would be expected to be followed by staff in the home. NM #101 said they were planning to order new lipped plates and bowls to replace the ones that were in circulation and had asked one of the dietary aides to check the condition of all the lipped plates.

The licensee has failed to ensure the "Meal Service and Dining Experience" policy and procedures included in the required Dietary Service and Hydration Program were complied with regarding the state of repair of dishware. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system, is complied with, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to, (a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that all food were stored and served using methods which preserved appearance and food quality.

The home's policy titled "temperatures of Food at point of Service NC-07-01-03" dated March 2019, stated "dietary staff shall serve food and beverages to each resident at a temperature and in a manner that promotes comfort and safety. We take the holding temperature of foods just before serving to ensure that hot foods are served and held for the duration of meal service outside the danger zone (above 60 degrees Celsius (C)/140 degrees Fahrenheit (F) and below 4 degrees C/40 degrees F)."

The home's "Tips on how to be successful with safe and pleasurable dining/nourishments" was posted in each dining room of the home. This document stated "every effort must be made to have trays assembled then delivered immediately so foods and fluids are served at safe and palatable temperatures."

On December 12, 2019, Inspector #630 observed the lunch meal service in the Riverside dining room and noted the following:
- at 1220 hours two soups were served by Dietary Aide (DA) #100 and placed on the shelf above the steamwell;
- at 1230 hours a Personal Support Worker (PSW) directed DA #100 to save a meal for a resident and DA #100 was observed serving a plate of macaroni and cheese with stewed tomatoes and placing it on a shelf above the steamwell.
- at 1232 hours DA #100 was directed by a PSW to save a meal for another resident and DA #100 served another portion of macaroni and cheese and placed it on the shelf above the steamwell;
- at 1236 hours DA #100 served a portion of salmon sandwich with macaroni and cheese on plate and placed it on the shelf above the steamwell;
- at 1247 hours DA #100 told Inspector #630 that these meals had been placed on the shelf as the staff had requested them to be saved for residents who were not in the dining room. DA#100 took the temperature of the macaroni and cheese and it was 44 degrees C, the salmon sandwich was 20 degrees C and the soup was 38 degrees C. DA #100 said these were not within the acceptable temperature ranges for hot or cold foods.
- at 1253 hours DA #100 left the delivery and the meals were still sitting on the shelf above the steamwell;
- at 1313 hours a PSW was observed taking one of the macaroni and cheese plates off the counter and said to another staff member that they were going to get it ready for a resident in their room;
- at 1317 hours Nutrition Manager (NM) #101 was called and came to the dining room. NM #101 was asked by Inspector #630 if the usual practice for storing and serving meals to residents who were not in the dining room was to keep it on the shelf, NM #101 said that the usual practice was not to save meals. NM #101 asked if it was the usual practice in the home to serve meals that were not held at the acceptable temperature, NM #101 said that the meals should be stored in the fridge. NM #101 then directed the PSW not to serve the meals and said they would get new meals from the kitchen for the residents.

On December 13, 2019, NM #101 said that staff were expected to follow the home's "Temperatures of Food at Point of Service" policy, including when saving meals that would be served to residents by tray service. NM #101 said that they had spoken to the dietary staff about not saving meals for residents on the counter the day before and they planned to communicate this practice to the PSWs in the home through the Director of Care (DOC). NM #101 said that the

staff were expected to be aware of the tips that were posted in the dining room as these had been placed in the dining rooms quite awhile ago by a former DOC.

The licensee has failed to ensure that all food were stored and served using methods which preserved appearance and food quality. [s. 72. (3) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the food production system are prepared, stored, and served using methods to preserve taste, nutritive value, appearance and food quality, to be implemented voluntarily.

Issued on this 31st day of July, 2020 (A2)

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DEBRA CHURCHER (670) - (A2)
Inspection No. / No de l'inspection :	2019_563670_0046 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	023114-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 31, 2020(A2)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Tecumseh 2475 St. Alphonse Street, TECUMSEH, ON, N8N-2X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tom Wilson

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 Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 O. Reg. s. 15. (2) (a)

Specifically;
A) The licensee shall schedule a deep clean of the home that includes but is not limited to wall surfaces, furnishings, serveries, vents, windows and doors, curtains and blinds, cabinets and cupboards, carts, counters and floors.
B) The licensee shall conduct weekly audits of the cleanliness of the home. The weekly audits shall be conducted by the Manager of Housekeeping Services, the Director of Care or the Administrator.
C) The licensee shall keep written records of the weekly audits that includes the date of the audit, any identified areas of concern, what corrective actions were implemented and the date of the corrective actions.

Grounds / Motifs :

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

The Ministry of Long-Term Care received a complaint IL-72634-LO on a specific date, related to concerns regarding the maintenance of the home.

On December 12, 2019, a tour of the facility was conducted by inspector #670 and

photos were taken.
Riverside Unit
-Noted missing flooring and damaged door jamb outside of clean utility room.
-Noted damaged blinds in the dining room with part of the blind laying on the window sill.
-Noted black duct tape that was peeling and lifted on the floor to the entrances of five specific rooms.
-Noted the main spa room to have damaged cabinets and damaged walls.
-Spa number two was noted to be out of service.
-Noted black tape to the dining room floor.

Lakeside Unit
-Noted the cabinets in spa number one to be damaged.
-Noted damaged baseboard outside a specific room.
-Noted damaged walls and base boards in spa room one, and outside of two specific rooms.

Oldcastle Unit
-Noted black tape that was peeling and lifting on the floor entering two specific rooms.
-Noted the wall outside a specific room to be damaged.
-Noted the wall and cabinets in spa number one to be damaged.

Livingstone Unit
-Noted the wall in spa number two to be damaged.
-Noted the cabinets in spa room number one to be damaged.
-Noted the wall to be damaged across from the Nurses station.
-Noted black tape that was peeling and lifting to the entry way of a specific room.
-Noted cracked and lifting tiles in two specific rooms.
-Noted broken and missing hand rail with the ends covered in tape on the wall entering the dining room.
Inspector #670 observed multiple areas of broken rubber baseboards on all units.

On December 13, 2019, an interview was conducted with acting Maintenance Manager (MM) #103 by inspector #670. MM #103 stated that they had been hired part time in February 2018 however due to budgetary issues they did not receive any regular hours. Stated that there was a plan for them to come in to do repair on walls

and rubber baseboards however the regular Maintenance Manager went off on a medical leave and they have been the acting Maintenance Manager since the beginning of November 2019. MM #103 acknowledged that they were aware of the multiple areas of damage in the home. MM #103 stated that the process in the home was for staff to document any concerns in the maintenance book at each nurse's stations and they would check the books every morning and address any concerns. MM #103 stated that this process does not always happen. MM #103 stated that the black tape on the floors that was peeling and lifting was a safety concern.

On December 13, 2019, an interview was conducted with Director of Care (DOC) #102 by Inspector #670. DOC #102 stated that expectation was that the home would be maintained in a safe condition and in a good state of repair and acknowledged that this expectation was not being met.

On December 12, 2019, Inspector #630 observed the serveries and dining rooms for all four resident home areas and identified the following:
- four out of four dining rooms had chipped paint throughout the room on the walls;
- two out of four dining rooms had food service carts with corners taped with duct tape which was peeling off;
- one out of four dining rooms had a damaged area on the floor covered with duct tape:
- one out of four dining rooms had damaged baseboards.

On December 13, 2019, Inspector #630 observed the serveries for all four resident home areas and identified the following:
- two out of four serveries had damaged walls;
- two out of four serveries had damaged baseboards;
- one out of four serveries had a hole in the floor by the doorway;
- two out of four serveries had damaged counter tops;
- two out of four serveries had damaged food services carts which were taped in areas with duct tape.

On December 13, 2019, Inspector #630 observed the doorway leading from the home's lobby area to the corridor of the main kitchen had two holes on the door frame on the right side.

On December 13, 2019, Nutrition Manager (NM) #101 said there was a process in

place for the nutrition staff to notify the maintenance department when there was a concern in the serveries or dining rooms. NM #101 said that they also looked for maintenance concerns when doing audits and had identified some concerns with the condition of the floor in the Riverside servery on December 12, 2019, which they were going to report to the maintenance department. Inspector #630 reviewed pictures taken of the serveries and dining rooms with NM #101 and they said that this did not meet the expectations in the home regarding the state of repair. Inspector #630, NM #101 and Administrator #107 then observed the Riverside servery and dining room and they said that these areas did not meet the expectations of the home in terms of the state of repair.

The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation.
(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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 O. Reg. s. 15. (2) (c)
Specifically;
A) The licensee shall schedule and complete repair in the home that includes but is not limited to, all damaged rubber baseboards, all damaged flooring including removal of peeling and lifted taped areas, all damaged walls, all damaged blinds, all damaged cabinets and counter tops and any other areas of disrepair or damage within the home.
B) The licensee shall schedule and complete education with all staff regarding the internal process of making a maintenance referral utilizing the maintenance book on each unit. The licensee shall keep records of the education provided that includes the date of the education and the staff members that received the education.
C) The licensee shall complete weekly audits of the overall maintenance and condition of the home. The weekly audits shall be conducted by the Manager of Maintenance Services, the Director of Care or the Administrator.
D) The licensee shall keep written records of the weekly audits that includes the date of the audit, any identified areas of concern, what corrective actions were implemented and the date of the corrective actions.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were

kept clean and sanitary.

The Ministry of Long-Term Care received a complaint IL-72634-LO on December 5, 2019, related to concerns regarding the cleanliness of the home.

On December 12, 2019, a tour of the facility was conducted by inspector #670 and photos were taken.
Riverside Unit
-Noted multiple visibly soiled areas on multiple wall surfaces.
-Noted the bumper baseboards to be coated in a large amount of dust and debris.
-Noted the patio door across from a specific room to be excessively soiled and large amount of dust and cobwebs noted.
-Noted multiple chairs and loveseats that were visibly stained.

Lakeside Unit
-Noted the patio door outside the Behavior Support office to be very soiled and noted cob webs and large amount of dust.
-Noted cobwebs dust and hair on the floor and on baseboards entering the dining room on the office side, outside the documentation room, and outside room a specific room.
-Noted soiled walls in spa room number one, outside a specific room and on the wall across from the nurses station.
-Noted multiple soiled love seats and chairs.

Oldcastle Unit
-Noted multiple chairs and love seats that were stained.
-Noted the patio door outside of a specific room to be soiled and have multiple cobwebs.
-Noted the wall outside two specific rooms and the wall outside the dining room to be visibly soiled.

Livingstone Unit
-Noted multiple chairs and loveseats to be stained.
-Noted the wall in spa 2 and the wall across from the nurse's station to be visibly soiled.
-Noted the patio door across from the activity room to be heavily soiled and have cobwebs and the rail across the patio door was also soiled.

On December 13, 2019, Inspector #670 and Housekeeping Manager (HM) #104 toured the Riverside unit and reviewed collected photographs. HM #104 acknowledged that the home was not clean. HM #104 stated that it was the expectation that the home and the furnishings would be kept clean and this was not being done to the expected standards.

On December 13, 2019, during an interview with Inspector #670 the Director of Care (DOC) #102 stated that expectation was that the home would be kept clean and sanitary including walls and furnishings and acknowledged that this expectation was not being met.

On December 12, 2019, Inspector #630 observed the dining rooms for all four resident home areas and identified the following:
- four out of four dining rooms had dirt and splatter throughout the room on the walls and hand rails;
- one out of four dining rooms had dirt build-up in the corner going into the room;
- four out of four dining rooms had dirt splatter on the blinds;
- two out of four dining rooms had black feeding assistance stool with dirt and spills on the base.

On December 13, 2019, Inspector #630 observed the serveries for all four resident home areas and identified the following:
- four out of four serveries had dirt and splatter throughout the room on the walls, front of cupboards and/or drawers;
- one out of four serveries had splatter and debris in the microwave;
- one out of four serveries had a food service cart with dirt and debris;
- the Riverside servery had dust build-up on the ceiling vent.

On December 13, 2019, Nutrition Manager (NM) #101 said the dietary aides were responsible for cleaning some of the areas in the serveries and dining rooms and the housekeeping staff were responsible for other cleaning tasks. Inspector #630 reviewed pictures taken of the serveries with NM #101 and they said that this did not meet the expectations in the home regarding cleanliness. Inspector #630, NM #101 and Administrator #107 then observed the Riverside servery and dining room and they said that these areas did not meet the expectations of the home in terms of cleanliness.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2020(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector

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

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 31st day of July, 2020 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DEBRA CHURCHER (670) - (A2)

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

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

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 DEBRA CHURCHER (670) - (A2)
Inspection No. / No de l'inspection :	2019_563670_0046 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	023114-19 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 31, 2020(A2)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Tecumseh 2475 St. Alphonse Street, TECUMSEH, ON, N8N-2X2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Tom Wilson

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 Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 O. Reg. s. 15. (2) (a)

Specifically;
A) The licensee shall schedule a deep clean of the home that includes but is not limited to wall surfaces, furnishings, serveries, vents, windows and doors, curtains and blinds, cabinets and cupboards, carts, counters and floors.
B) The licensee shall conduct weekly audits of the cleanliness of the home. The weekly audits shall be conducted by the Manager of Housekeeping Services, the Director of Care or the Administrator.
C) The licensee shall keep written records of the weekly audits that includes the date of the audit, any identified areas of concern, what corrective actions were implemented and the date of the corrective actions.

Grounds / Motifs :

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

The Ministry of Long-Term Care received a complaint IL-72634-LO on a specific date, related to concerns regarding the maintenance of the home.

On December 12, 2019, a tour of the facility was conducted by inspector #670 and

photos were taken.
Riverside Unit
-Noted missing flooring and damaged door jamb outside of clean utility room.
-Noted damaged blinds in the dining room with part of the blind laying on the window sill.
-Noted black duct tape that was peeling and lifted on the floor to the entrances of five specific rooms.
-Noted the main spa room to have damaged cabinets and damaged walls.
-Spa number two was noted to be out of service.
-Noted black tape to the dining room floor.

Lakeside Unit
-Noted the cabinets in spa number one to be damaged.
-Noted damaged baseboard outside a specific room.
-Noted damaged walls and base boards in spa room one, and outside of two specific rooms.

Oldcastle Unit
-Noted black tape that was peeling and lifting on the floor entering two specific rooms.
-Noted the wall outside a specific room to be damaged.
-Noted the wall and cabinets in spa number one to be damaged.

Livingstone Unit
-Noted the wall in spa number two to be damaged.
-Noted the cabinets in spa room number one to be damaged.
-Noted the wall to be damaged across from the Nurses station.
-Noted black tape that was peeling and lifting to the entry way of a specific room.
-Noted cracked and lifting tiles in two specific rooms.
-Noted broken and missing hand rail with the ends covered in tape on the wall entering the dining room.
Inspector #670 observed multiple areas of broken rubber baseboards on all units.

On December 13, 2019, an interview was conducted with acting Maintenance Manager (MM) #103 by inspector #670. MM #103 stated that they had been hired part time in February 2018 however due to budgetary issues they did not receive any regular hours. Stated that there was a plan for them to come in to do repair on walls

and rubber baseboards however the regular Maintenance Manager went off on a medical leave and they have been the acting Maintenance Manager since the beginning of November 2019. MM #103 acknowledged that they were aware of the multiple areas of damage in the home. MM #103 stated that the process in the home was for staff to document any concerns in the maintenance book at each nurse's stations and they would check the books every morning and address any concerns. MM #103 stated that this process does not always happen. MM #103 stated that the black tape on the floors that was peeling and lifting was a safety concern.

On December 13, 2019, an interview was conducted with Director of Care (DOC) #102 by Inspector #670. DOC #102 stated that expectation was that the home would be maintained in a safe condition and in a good state of repair and acknowledged that this expectation was not being met.

On December 12, 2019, Inspector #630 observed the serveries and dining rooms for all four resident home areas and identified the following:
- four out of four dining rooms had chipped paint throughout the room on the walls;
- two out of four dining rooms had food service carts with corners taped with duct tape which was peeling off;
- one out of four dining rooms had a damaged area on the floor covered with duct tape:
- one out of four dining rooms had damaged baseboards.

On December 13, 2019, Inspector #630 observed the serveries for all four resident home areas and identified the following:
- two out of four serveries had damaged walls;
- two out of four serveries had damaged baseboards;
- one out of four serveries had a hole in the floor by the doorway;
- two out of four serveries had damaged counter tops;
- two out of four serveries had damaged food services carts which were taped in areas with duct tape.

On December 13, 2019, Inspector #630 observed the doorway leading from the home's lobby area to the corridor of the main kitchen had two holes on the door frame on the right side.

On December 13, 2019, Nutrition Manager (NM) #101 said there was a process in

place for the nutrition staff to notify the maintenance department when there was a concern in the serveries or dining rooms. NM #101 said that they also looked for maintenance concerns when doing audits and had identified some concerns with the condition of the floor in the Riverside servery on December 12, 2019, which they were going to report to the maintenance department. Inspector #630 reviewed pictures taken of the serveries and dining rooms with NM #101 and they said that this did not meet the expectations in the home regarding the state of repair. Inspector #630, NM #101 and Administrator #107 then observed the Riverside servery and dining room and they said that these areas did not meet the expectations of the home in terms of the state of repair.

The licensee has failed to ensure that the home was maintained in a safe condition and in a good state of repair.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation.
(670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 17, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

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 O. Reg. s. 15. (2) (c)
Specifically;
A) The licensee shall schedule and complete repair in the home that includes but is not limited to, all damaged rubber baseboards, all damaged flooring including removal of peeling and lifted taped areas, all damaged walls, all damaged blinds, all damaged cabinets and counter tops and any other areas of disrepair or damage within the home.
B) The licensee shall schedule and complete education with all staff regarding the internal process of making a maintenance referral utilizing the maintenance book on each unit. The licensee shall keep records of the education provided that includes the date of the education and the staff members that received the education.
C) The licensee shall complete weekly audits of the overall maintenance and condition of the home. The weekly audits shall be conducted by the Manager of Maintenance Services, the Director of Care or the Administrator.
D) The licensee shall keep written records of the weekly audits that includes the date of the audit, any identified areas of concern, what corrective actions were implemented and the date of the corrective actions.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were

kept clean and sanitary.

The Ministry of Long-Term Care received a complaint IL-72634-LO on December 5, 2019, related to concerns regarding the cleanliness of the home.

On December 12, 2019, a tour of the facility was conducted by inspector #670 and photos were taken.
Riverside Unit
-Noted multiple visibly soiled areas on multiple wall surfaces.
-Noted the bumper baseboards to be coated in a large amount of dust and debris.
-Noted the patio door across from a specific room to be excessively soiled and large amount of dust and cobwebs noted.
-Noted multiple chairs and loveseats that were visibly stained.

Lakeside Unit
-Noted the patio door outside the Behavior Support office to be very soiled and noted cob webs and large amount of dust.
-Noted cobwebs dust and hair on the floor and on baseboards entering the dining room on the office side, outside the documentation room, and outside room a specific room.
-Noted soiled walls in spa room number one, outside a specific room and on the wall across from the nurses station.
-Noted multiple soiled love seats and chairs.

Oldcastle Unit
-Noted multiple chairs and love seats that were stained.
-Noted the patio door outside of a specific room to be soiled and have multiple cobwebs.
-Noted the wall outside two specific rooms and the wall outside the dining room to be visibly soiled.

Livingstone Unit
-Noted multiple chairs and loveseats to be stained.
-Noted the wall in spa 2 and the wall across from the nurse's station to be visibly soiled.
-Noted the patio door across from the activity room to be heavily soiled and have cobwebs and the rail across the patio door was also soiled.

On December 13, 2019, Inspector #670 and Housekeeping Manager (HM) #104 toured the Riverside unit and reviewed collected photographs. HM #104 acknowledged that the home was not clean. HM #104 stated that it was the expectation that the home and the furnishings would be kept clean and this was not being done to the expected standards.

On December 13, 2019, during an interview with Inspector #670 the Director of Care (DOC) #102 stated that expectation was that the home would be kept clean and sanitary including walls and furnishings and acknowledged that this expectation was not being met.

On December 12, 2019, Inspector #630 observed the dining rooms for all four resident home areas and identified the following:
- four out of four dining rooms had dirt and splatter throughout the room on the walls and hand rails;
- one out of four dining rooms had dirt build-up in the corner going into the room;
- four out of four dining rooms had dirt splatter on the blinds;
- two out of four dining rooms had black feeding assistance stool with dirt and spills on the base.

On December 13, 2019, Inspector #630 observed the serveries for all four resident home areas and identified the following:
- four out of four serveries had dirt and splatter throughout the room on the walls, front of cupboards and/or drawers;
- one out of four serveries had splatter and debris in the microwave;
- one out of four serveries had a food service cart with dirt and debris;
- the Riverside servery had dust build-up on the ceiling vent.

On December 13, 2019, Nutrition Manager (NM) #101 said the dietary aides were responsible for cleaning some of the areas in the serveries and dining rooms and the housekeeping staff were responsible for other cleaning tasks. Inspector #630 reviewed pictures taken of the serveries with NM #101 and they said that this did not meet the expectations in the home regarding cleanliness. Inspector #630, NM #101 and Administrator #107 then observed the Riverside servery and dining room and they said that these areas did not meet the expectations of the home in terms of cleanliness.

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

The severity was determined to be a level 2 as there was minimal harm or potential for actual harm. The scope of this issue was widespread during the course of this inspection. The home does not have a history of non-compliance in this subsection of the legislation. (670)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2020(A2)

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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

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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

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

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

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

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

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

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

Issued on this 31st day of July, 2020 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by DEBRA CHURCHER (670) - (A2)

Ontario

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