

**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**Central West Service Area Office
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WATERLOO ON N2V 1K8
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Ouest
1e étage, 609 rue Kumpf
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Télécopieur: (519) 885-2015**Public Copy/Copie 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
Feb 11, 2020	2020_796754_0003	012527-19, 000291-20	Critical Incident System

Licensee/Titulaire de permisGolden Dawn Senior Citizen Home
80 Main Street Lion's Head ON N0H 1W0**Long-Term Care Home/Foyer de soins de longue durée**Golden Dawn Nursing Home
80 Main Street Lion's Head ON N0H 1W0**Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs**

TAWNIE URBANSKI (754)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): January 15, 16, 17, 2020.

The following intakes were completed during this inspection:

Log #000291-20- A CI related to a fall resulting in a significant change in status.

Log #012527-19- A follow up related to 24/7 RN staffing.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Personal Support Workers (PSW's), Registered Practical Nurses (RPN's), and a Registered Nurse (RN).

The inspector also made observations of resident home areas, and resident/staff interactions. A record review of the clinical records of the identified resident was completed including resident plans of care, assessments, and point of care documentation. Review of Registered Staff schedules was completed, in addition to relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Falls Prevention

Sufficient Staffing

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

1 WN(s)

0 VPC(s)

1 CO(s)

0 DR(s)

0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

<p>Legend</p> <p>WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order</p>	<p>Légende</p> <p>WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités</p>
<p>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).</p> <p>The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.</p>	<p>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.</p> <p>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.</p>

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The LTCH Inspector conducted a follow-up inspection related to CO #001 from inspection #2019_787640_0017 regarding the LTCHA, s. 8 (3), with a CDD of January 6, 2020, wherein the home did not have an RN on duty and present in the home at all times.

The LTCH Inspector reviewed the Registered Nurse (RN) schedules for a ten day period during the month of January 2020. There were 5 day shifts where there was no RN present in the home that was a regular member of the nursing staff.

Registered Practical Nurse (RPN) #106 said they were working today without an RN in the building. The RPN said that RN staffing was better now as they were not left alone on their shift anymore, but the RN staffing was still not where it should be.

Administrator #100 and Director of Care (DOC) #101 reviewed the schedule and acknowledged there was no RN on site for 5 day shifts during the eleven day period reviewed in January 2020. The DOC acknowledged that on five of the eleven day shifts (45 per cent) there was no RN in the home, who was a regular member of the nursing staff.

The licensee has failed to ensure that at least one registered nurse, who was both an employee of the licensee and a member of the regular nursing staff of the home, was on duty and present in the home at all times. [s. 8. (3)]

Additional Required Actions:

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

Issued on this 12th day of February, 2020

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

Original report signed by the inspector.

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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) : TAWNIE URBANSKI (754)

Inspection No. /

No de l'inspection : 2020_796754_0003

Log No. /

No de registre : 012527-19, 000291-20

Type of Inspection /

Genre d'inspection: Critical Incident System

Report Date(s) /

Date(s) du Rapport : Feb 11, 2020

Licensee /

Titulaire de permis : Golden Dawn Senior Citizen Home
80 Main Street, Lion's Head, ON, N0H-1W0

LTC Home /

Foyer de SLD : Golden Dawn Nursing Home
80 Main Street, Lion's Head, ON, N0H-1W0

Name of Administrator /

Nom de l'administratrice

ou de l'administrateur : Barbara Sterling

To Golden Dawn Senior Citizen Home, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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2007, chap. 8

Order # /

No d'ordre : 001

Order Type /

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

Linked to Existing Order / 2019_787640_0017, CO #001;
Lien vers ordre existant:

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must comply with the LTCHA, 2007, s. 8 (3).

Specifically, the licensee must:

- 1) Ensure there is at least one RN, who is both an employee of the licensee and a member of the regular nursing staff, on duty and present in the home at all times.
- 2) Track and record recruitment strategies that have been implemented including the date of each strategy and its outcome.

Grounds / Motifs :

1. The licensee has failed to comply with CO #001 from inspection #2019_787640_0017, issued on June 19, 2019, with a compliance date of January 6, 2020.

The licensee was ordered to:

Specifically, the licensee must:

- 1) Track and record the recruitment strategies that have been implemented and the date of each strategy, the number of interviews with Registered Nurses (RN), the number and dates of employment offers and acceptances of RNs and number of RNs that have resigned their position and the dates of the

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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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

resignations and,

2) ensure there is an RN, who is a member of the regular nursing staff, on duty and present in the home at all times.

The licensee completed step 1 in CO #001,

The licensee failed to complete step 2 in CO #001 regarding ensuring there is an RN, who is a member of the regular nursing staff, on duty and present in the home at all times.

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

The LTCH Inspector conducted a follow-up inspection related to CO #001 from inspection #2019_787640_0017 regarding the LTCHA, s. 8 (3), with a CDD of January 6, 2020, wherein the home did not have an RN on duty and present in the home at all times.

The LTCH Inspector reviewed the Registered Nurse (RN) schedules for a ten day period during the month of January 2020. There were 5 day shifts where there was no RN present in the home that was a regular member of the nursing staff.

Registered Practical Nurse (RPN) #106 said they were working today without an RN in the building. The RPN said that RN staffing was better now as they were not left alone on their shift anymore, but the RN staffing was still not where it should be.

Administrator #100 and Director of Care (DOC) #101 reviewed the schedule and acknowledged there was no RN on site for 5 day shifts during the eleven day period reviewed in January 2020. The DOC acknowledged that on five of the eleven day shifts (45 per cent) there was no RN in the home, who was a regular member of the nursing staff.

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

Order(s) of the Inspector

Pursuant to section 153 and/or
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Care Homes Act, 2007*, S.O.
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Ordre(s) de l'inspecteur

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foyers de soins de longue durée*, L.O.
2007, chap. 8

The severity of this issue was determined to be level 2, minimal risk of harm. The scope of the issue was determined to be level 3, widespread, as no RN on duty at the home effects all the residents. The compliance history was determined to be level 4 as there were three previous compliance orders related to the same area as follows:

- Complaint inspection #2019_787640_0017 with CO #001 issued June 19, 2019, with a compliance due date of January 6, 2020.
- Follow up inspection #2018_580568_0017 with CO #001 issued November 9, 2018, with a compliance due date of January 11, 2019.
- Resident Quality Inspection #2017_580568_0021 with CO #001 issued October 31, 2017, with a compliance due date of December 31, 2017. (754)

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

Oct 01, 2020

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or
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2007, c. 8

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2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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.

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2007, c. 8

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2007, chap. 8

**RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX
APPELS**

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Order(s) of the Inspector**Ordre(s) de l'inspecteur**

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

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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 révision
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 11th day of February, 2020

Signature of Inspector /

Signature de l'inspecteur :

Name of Inspector /

Nom de l'inspecteur : Tawnie Urbanski

Service Area Office /

Bureau régional de services : Central West Service Area Office