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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
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
Jul 16, 2020	2020_796754_0017	001381-20, 002666-20, 005662-20	Critical Incident System

Licensee/Titulaire de permis

Golden 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): July 6-8, 2020.

The following intakes were completed during this Critical Incident Inspection:
Log #002666-20, a follow up intake related to a CO for bathing,
Log #001381-20, related to an allegation of abuse; and,
Log #005662-20, related to responsive behaviors.

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

The inspector made observations of resident care and resident/staff interactions. A record review of the plan of care of the identified residents were completed. The home's relevant documentation were also reviewed.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Responsive Behaviours

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home was bathed, at a

minimum, twice per week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The LTCH Inspector conducted a follow-up inspection related to CO #001 from inspection #2020_796754_0003, regarding the O. Regs. 33 (1), with a CDD of May 1, 2020, wherein the home failed to ensure each resident of the home was bathed at a minimum twice per week by a method of their choice.

A) Resident #001 said they rarely received their bathing method of choice as repairs were needed in the bathing room.

Review of the home's Point Click Care documentation for bathing showed that resident #001 was to receive their preferred method of bathing twice per week. Review of resident #001's Point of Care documentation for a one month period, showed the resident missed three out of the nine scheduled bathing days.

Personal Support Worker (PSW) #102 said the home did not have adequate staffing to complete all scheduled baths.

Administrator #100 said that resident #001 missed one of their bathing days due to repairs occurring in the bathing room. They said they missed their other bathing due to staffing shortages in the home.

B) Resident #005 said it was hard for staff to give them their preferred method of bathing twice per week.

Review of the home's Point Click Care documentation for bathing documented that resident #005 was to receive their preferred method of bathing twice per week. Review of resident #001's Point of Care documentation for a one month period, showed the resident missed one of their scheduled bathing days and received their non preferred bathing method three times during this period.

PSW #102 said the home did not have adequate staffing to complete all scheduled bathing and resident #005 missed their bathing a few times during the month of June. PSW #102 said that they were off Fridays and their bathing shift was not covered.

Administrator #100 said that resident #005 missed one of their bathing days in June

2020, as there was no one working to cover the bathing shift that day.

The licensee failed to ensure that resident #001 and resident #005 were bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. [s. 33. (1)]

Additional Required Actions:

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

Issued on this 21st day of July, 2020

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) :	TAWNIE URBANSKI (754)
Inspection No. / No de l’inspection :	2020_796754_0017
Log No. / No de registre :	001381-20, 002666-20, 005662-20
Type of Inspection / Genre d’inspection:	Critical Incident System
Report Date(s) / Date(s) du Rapport :	Jul 16, 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

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)

Linked to Existing Order / Lien vers ordre existant: 2020_796754_0004, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

A) Ensure that resident #001 and #005 are provided bathing, by the method of their choice, at a minimum twice per week.

Grounds / Motifs :

1. The licensee has failed to comply with CO #001 from inspection #2020_796754_0004 issued on February 11, 2020, with a compliance due date of May 1, 2020.

The licensee was ordered to:

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

Specifically, the licensee must:

A) Ensure that resident #002, #005, and #006 are provided bathing, by the method of their choice, at a minimum twice per week.

B) That there is a written process in place that identifies the residents' bathing preferences, tracks the method by which they were bathed, when they were

bathed, when bathing was missed and a plan to make up missed baths/showers.

The licensee completed step B in CO #001.
The licensee failed to complete step A in CO #001, related to bathing residents at minimum twice per week.

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice per week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The LTCH Inspector conducted a follow-up inspection related to CO #001 from inspection #2020_796754_0003, regarding the O. Regs. 33 (1), with a CDD of May 1, 2020, wherein the home failed to ensure each resident of the home was bathed at a minimum twice per week by a method of their choice.

A) Resident #001 said they rarely received their bathing method of choice as repairs were needed in the bathing room.

Review of the home's Point Click Care documentation for bathing showed that resident #001 was to receive their preferred method of bathing twice per week. Review of resident #001's Point of Care documentation for a one month period, showed the resident missed three out of the nine scheduled bathing days.

Personal Support Worker (PSW) #102 said the home did not have adequate staffing to complete all scheduled baths.

Administrator #100 said that resident #001 missed one of their bathing days due to repairs occurring in the bathing room. They said they missed their other bathing due to staffing shortages in the home.

B) Resident #005 said it was hard for staff to give them their preferred method of bathing twice per week.

Review of the home's Point Click Care documentation for bathing documented that resident #005 was to receive their preferred method of bathing twice per

week. Review of resident #001's Point of Care documentation for a one month period, showed the resident missed one of their scheduled bathing days and received their non preferred bathing method three times during this period.

PSW #102 said the home did not have adequate staffing to complete all scheduled bathing and resident #005 missed their bathing a few times during the month of June. PSW #102 said that they were off Fridays and their bathing shift was not covered.

Administrator #100 said that resident #005 missed one of their bathing days in June 2020, as there was no one working to cover the bathing shift that day.

The licensee failed to ensure that resident #001 and resident #005 were bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The severity of this issue was a level 2 as there was minimal harm to residents. The scope was level 2 as two out of three residents were reviewed. The home has a level 4 compliance history as there was previous non-compliance with the same subsection that included:
-Compliance order (CO) made under s. 33(1) of the Regulations, February 11, 2020, (#2020_796754_0004) with a compliance date of May 1, 2020.
Additionally, the LTCH has a history of other 16 WNs, 6 VPCs, 1 director referral and 7 compliance orders to other subsections in the last 36 months.
(754)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 10, 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 16th day of July, 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