

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
May 20, 2021	2021_575214_0007	004236-21	Complaint

Licensee/Titulaire de permis

Pleasant Manor Retirement Village
15 Elden Street Box 500 Virgil ON L0S 1T0

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

Pleasant Manor Retirement Village
15 Elden Street Box 500 Virgil ON L0S 1T0

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

CATHY FEDIASH (214)

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): April 26, 27, 28, 29, May 4, 5, 6, 7, and 10, 2021.

Please note the following:

This inspection was conducted simultaneously with Critical Incident System (CIS) inspection #2021_575214_0008.

The following intakes were completed during this complaint inspection:

-Log #004236-21- in relation to Infection Prevention and Control, Medications, Safe and Secure home.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Maintenance Manager, Registered Nursing staff, Personal Support Workers (PSW) and residents.

During the course of the inspection, the inspector reviewed clinical health records, relevant policy and procedures, home's project summary application, letter from a vendor regarding a system installation, infection prevention and control records, observed relevant infection prevention and control practices and observed the administration of medication.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance

Infection Prevention and Control

Medication

Safe and Secure Home

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

1 WN(s)

0 VPC(s)

0 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 O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (3) The licensee shall ensure that the Director is informed of the following incidents in the home no later than one business day after the occurrence of the incident, followed by the report required under subsection (4):

2. An environmental hazard that affects the provision of care or the safety, security or well-being of one or more residents for a period greater than six hours, including,

- i. a breakdown or failure of the security system,**
- ii. a breakdown of major equipment or a system in the home,**
- iii. a loss of essential services, or**
- iv. flooding.**

O. Reg. 79/10, s. 107 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was informed of the breakdown of the home's communication response system for a period greater than six hours, no later than one business day after the occurrence of the incident.

An off-site complaint inquiry conducted with the home, confirmed that the home's resident-staff communication and response system was not functioning and required replacement.

A project summary document, submitted by the home eight days later, for an emergency replacement of the resident-staff communication and response system, indicated the call bell system had stopped working approximately two months prior.

It was confirmed that the resident-staff communication and response system had been replaced and fully functioning, at the time of the inspection.

It was confirmed the Director had not been informed when the home's communication response system failed to work and required replacement as the home was unsure if this met the reporting requirements and at the same time, were managing the COVID-19 pandemic and forgot to report.

Sources: Off-site inquiry, call bell replacement project summary document and interviews with the DOC and other staff. [s. 107. (3) 2.]

Issued on this 21st day of May, 2021

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

Original report signed by the inspector.