Ontario

**Inspection Report Under the**
**Fixing Long-Term Care Act, 2021**

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

**Central East District**
33 King Street West, 4th Floor
Oshawa, ON, L1H 1A1
Telephone: (844) 231-5702

# Original Public Report

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| **Report Issue Date: July 29, 2024** |
| **Inspection Number:** 2024-1498-0003 |
| **Inspection Type:**<br>Proactive Compliance Inspection |
| **Licensee:** Royal Canadian Legion District 'D' Care Centres |
| **Long Term Care Home and City:** Tony Stacey Centre for Veterans' Care, Toronto |

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 19-21, 24-28, 2024

The following intake(s) were inspected:

- Intake - Proactive Compliance Inspection

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services
Skin and Wound Prevention and Management
Residents' and Family Councils
Food, Nutrition and Hydration
Medication Management
Safe and Secure Home
Infection Prevention and Control
Prevention of Abuse and Neglect
Quality Improvement
Residents' Rights and Choices
Pain Management

Falls Prevention and Management

# INSPECTION RESULTS

## WRITTEN NOTIFICATION: Food production

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 78 (2) (g)**

Food production

s. 78 (2) The food production system must, at a minimum, provide for,

(g) documentation on the production sheet of any menu substitutions. O. Reg. 246/22, s. 78 (2).

The licensee has failed to document on the production sheet of any menu substitutions.

**Rationale and Summary**

While conducting a Proactive Compliance Inspection (PCI), it was discovered the Long-Term Care Home (LTCH) was not updating the production sheets with menu substitutions when there was a change in menu items. The home's weekly (1) menu indicated the Wednesday Dinner dessert was blueberry shortcake, however the home substituted for strawberry shortcake with no update on the production sheet. The Week (2) Thursday Dinner was pilaf rice and was substituted for mash potatoes, which was not reflected on the production sheet.

The Food Service Manager (FSM) confirmed they do not always update the production sheets when there is a menu item substitution because it does not affect the quantity of the item.

By failing to update the production sheets when substitutions are made can lead to misrepresentation of data collection.

**Sources:** Production sheets, Weekly Menu, Interview with FSM.

## WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 166 (2) 5.**
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
5. The home's registered dietitian.

The licensee has failed to ensure that the continuous quality improvement committee for a home shall be composed of at least the following persons, the home's registered dietitian.

**Rationale and Summary**

The Administrator indicated that the long-term care home had an established continuous quality improvement committee that included the Administrator, DIrector of Care, Administrative Director of Care, and Office Manager.

The Administrator confirmed the Registered Dietician was not a part of the committee. A review of the long-term care home's Continuous Quality Initiative meeting minutes indicated that the home's registered dietitian was not in attendance.
Failure to include at least the following person(s), the home's registered dietitian, impacts engagement of stakeholders in the effort to improve care and services.

**Sources:** CQI report 2023/2024, CQI meeting minutes, interviews with the Administrator.

## WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: O. Reg. 246/22, s. 166 (2) 6.**

Continuous quality improvement committee

s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:

6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

The licensee has failed to ensure that the continuous quality improvement committee for a home, shall be composed of at least the following persons, the home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

**Rationale and Summary**

The Administrator indicated that the long-term care home had an established continuous quality improvement committee that included the Administrator, DIrector of Care, Administrative Director of Care, and Office Manager.

The Administrator confirmed a pharmacist from the pharmacy provider was not a part of the committee. A review of the long-term care home's CQI meeting minutes indicated that a pharmacist from the pharmacy service provider was not in attendance.

Failure to include at least the following person(s), a pharmacist from the pharmacy service provider, impacts engagement of stakeholders in the effort to improve care and services.

**Sources:** CQI report, CQI meeting minutes, interview with Administrator.

## WRITTEN NOTIFICATION: Continuous Quality Improvement Committee

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 166 (2) 7.**
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
7. At least one employee of the licensee who is a member of the regular nursing staff of the home.

The licensee has failed to ensure that the continuous quality improvement committee for a home, shall be composed of at least the following persons, at least one employee of the licensee who is a member of the regular nursing staff of the home.

**Rationale and Summary**

The Administrator indicated that the long-term care home had an established continuous quality improvement committee that included the Administrator, DIrector of Care, Administrative Director of Care, and Office Manager.

The Administrator confirmed a registered staff of the home was not a part of the committee. A review of the CQI meeting minutes indicated that a registered staff of the home was not in attendance.

Failure to include at least the following person(s), at least one employee of the licensee who is a member of the regular nursing staff of the home, impacts engagement of stakeholders in the effort to improve care and services.

**Sources:** CQI report, CQI meeting minutes, interviews with the Administrator.

## WRITTEN NOTIFICATION: Continuous Quality Improvement

## Committee

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 166 (2) 8.**
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

The licensee has failed to ensure that the continuous quality improvement committee for a home, shall be composed of at least the following persons, at least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.

**Rationale and Summary**

The Administrator indicated that the long-term care home had an established continuous quality improvement committee that included the Administrator, DIrector of Care, Administrative Director of Care, and Office Manager.

The Administrator confirmed a personal support worker was not a part of the committee. A review of the long-term care home's CQI meeting minutes indicated that a personal support worker was not in attendance.

Failure to include at least the following person(s), a personal support worker, impacts engagement of stakeholders in the effort to improve care and services.

**Sources**: CQI report, CQI meeting minutes, interviews with the Administrator.

## WRITTEN NOTIFICATION: Continuous Quality Improvement

## Committee

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
**Non-compliance with: O. Reg. 246/22, s. 166 (2) 9.**
Continuous quality improvement committee
s. 166 (2) The continuous quality improvement committee shall be composed of at least the following persons:
9. One member of the home's Residents' Council.

The licensee has failed to ensure that the continuous quality improvement committee for a home, shall be composed of at least the following persons, one member of the home's Residents' Council.

**Rationale and Summary**

The Administrator indicated that the long-term care home had an established continuous quality improvement committee that included the Administrator, DIrector of Care, Administrative Director of Care, and Office Manager.

The Administrator confirmed a member of the resident's council was not a part of the committee. A review of the long-term care home's CQI meeting minutes indicated that a member of the resident's council was not present.
Failure to include at least the following person(s), a member of the resident's council, impacts engagement of stakeholders in the effort to improve care and services.
**Sources:** CQI report, CQI meeting minutes, interviews with the Administrator.

## COMPLIANCE ORDER CO #001 Construction, renovation, etc., of homes

NC #007 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 356 (3) 1.**

Construction, renovation, etc., of homes
s. 356 (3) A licensee may not commence any of the following work without first receiving the approval of the Director:
1. Alterations, additions or renovations to the home.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. The home's management team will return all showers and bathrooms that are designated for resident use, back to the intended design plan and operational as a resident shower room. This will also include any shower rooms that are being used for storage will be returned to resident space as well as repair of any shower rooms that are not in good working order. The Administrator will ensure LTCH staff do not use resident designated bathrooms. Maintain a documented record of the communication to staff, the date of the communication, the list of designated showers and bathrooms for resident use only.

2. Create and post signs on the door to indicate the name of the rooms (shower/tub room.) and identify it is for resident use.

3. The ESM to conduct random audits for a period of six weeks, four times a week during the time period of 0800 hours to 1600 hours of each resident shower/tub rooms to ensure staff are not using areas for personal use. Analyze the results of the audits and provide on-the-spot education to staff if non-compliance were identified. Maintain documented records of the audits, including at a minimum, the date of the audits, the location/area of the audit, the specific resident shower and tub room name and location, the results of the audit, the name of the person conducting the audit.

4. Make the records available to the inspector immediately upon request.

**Grounds**

The licensee has failed to ensure that alterations were not made to the home without first receiving the approval of the Director.

**Rationale and Summary**

During an Infection Prevention and Control (IPAC) observation it was noted a resident shower room had a paper printed sign which stated for "staff only." PSW #106 confirmed the shower rooms were used by the staff only. During an observation it was noted most of the resident designated shower and tub rooms were either being used by staff, not working, or used for storage.

Observations conducted on the first floor are as follow:

- Tub Room Northside: Staff were using it as Restroom. Inspector saw PSW #107 coming out of the room. When asked by the inspector, the staff stated, the restroom was for staff use.
- Shower Room Eastside: Staff were using the restroom. Inspector saw PSW #108 exiting after use. When asked by inspector why they were using the restroom in the shower room, the staff replied by saying that they were informed they could use this room.

Observations conducted on the second floor with PSW #109:

- Shower Room Eastside: PSW #109 stated staff and resident are using shower room.
- Shower Room Southside: Shower noted to be broken and staff were using the toilet.

The Administrator indicated they had informed staff to remove all signs and not to use the resident spaces and would address the concerns.

Failure to notify the Director when the resident spaces were altered, reduced the available space for residents to use and sharing of the room can increase the risk of infections.

**Sources:** Observations, Interview with Administrator and PSWs #106, #107, #109.

**This order must be complied with by** September 25, 2024

## COMPLIANCE ORDER CO #002 Air temperature

NC #008 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

**Non-compliance with: O. Reg. 246/22, s. 24 (2)**

Air temperature

s. 24 (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:

1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. The Administrator, Environmental Service Manager, and Maintenance staff will develop and implement a process to ensure air temperature is measured and documented in writing in the following areas of the home: At least two resident bedrooms in different parts of the home, one resident common area on every floor of the home, which may include a lounge, dining area or corridor, and every designated cooling area. The process shall include who will be responsible to take the air temperatures, when to take them, and what to do if the air temperature is below 22 degrees or above 26 degrees. The new process will be communicated to all staff. The home will maintain records of the communication to staff, which include, staff names, the date of the communication, the name of the person(s)

providing the communication.

2. The Environmental Service Manager or management designate is to complete daily audits for a period of four weeks to ensure air temperatures are being measured and documented in writing in all areas of the home as per legislative requirements. The audit shall include the name of the person completing the audit, the date it was completed, the location of areas audited, and any corrective actions made.

3. Make the records available to the inspector immediately upon request.

**Grounds**

The licensee has failed to ensure that the air temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home, one resident common area on every floor of the home, and every designated cooling area.

**Rationale and Summary**

As part of the inspection, the home was asked to produce air temperature logs for the home. Maintenance staff informed inspector the home used a "Daily Maintenance Inspection" wherein the maintenance staff were to complete various maintenance tasks. Part of the daily maintenance inspection included ensuring supply air in common areas was under 26 degrees, however there was no indication to identify which common areas in the home were to be checked. In reviewing the Daily Maintenance Inspection sheets, no air temperatures were written, but rather checked off to indicate the air temperature was below 26 degrees.

The home's "Hot Weather Prevention and Illness Management" policy indicated it was the environmental service manager's responsibility to ensure air temperatures were measured in at least two resident rooms in different areas of the home and

one resident common area on every floor of the home. Maintenance staff #101 indicated the home currently did not have an environmental service manager and the program was being overlooked by an individual at head office who was to come into the home once a week. Maintenance staff #101 confirmed temperatures were not taken in resident rooms or in the homes designated cooling area, which was in the basement. The common areas that air temperature were taken in, were in the hallways on the resident home areas. The home was unable to produce air temperature measurements in any resident rooms, common areas, or the designated cooling areas.

There was risk that the air temperature was not within a safe or comfortable range when it was not measured or documented in any resident rooms, common areas, and designated cooling areas.

**Sources:** Daily Maintenance Inspection sheets, home's "Hot Weather Prevention and Illness Management" policy, interviews with staff.

**This order must be complied with by** September 16, 2024

## COMPLIANCE ORDER CO #003 Air temperature

NC #009 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
**Non-compliance with: O. Reg. 246/22, s. 24 (3)**
Air temperature
s. 24 (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

**The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:**

1. The Administrator, Environmental Service Manager, and Maintenance staff will develop and implement a process to ensure temperature is measured and documented in writing in the following areas of the home: At least two resident bedrooms in different parts of the home, one resident common area on every floor of the home, which may include a lounge, dining area or corridor, and every designated cooling area at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

2) The Environmental Service Manager is to complete daily audits for a period of four weeks to ensure temperatures are being measured and documented in writing in all areas of the home at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night as per legislative requirements. The audit shall include the name of the person completing the audit, locations of areas audited, the date it was completed, and any corrective actions made.

3.) Make the records available to the inspector immediately upon request.

**Grounds**

The licensee has failed to ensure that the temperature required to be measured under Ontario Regulation 246/22 s. 24 (2), was measured or documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

**Rationale and Summary**

As part of the inspection, the home was asked to produce air temperature logs for the home. Maintenance staff informed inspector the home used a "Daily Maintenance Inspection" wherein the maintenance staff were to complete various maintenance tasks. Part of the daily maintenance inspection included ensuring supply air in common areas was under 26 degrees, however there was no indication

to identify which common areas in the home were to be checked. In reviewing the Daily Maintenance Inspection sheets, no air temperatures were written, but rather checked off to indicate the air temperature was below 26 degrees.

Maintenance staff #101 confirmed the air temperature was not taken three times a day, but rather once a day, usually in the mornings or afternoons.
There was risk that the air temperature was not within a safe or comfortable range when it was not measured at all of the required times.

**Sources:** Daily Maintenance Inspection sheet, Interview with staff.

**This order must be complied with by** September 16, 2024

## REVIEW/APPEAL INFORMATION

**TAKE NOTICE**The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

**Director**
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

**Health Services Appeal and Review Board**
Attention Registrar
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
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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