Ontario

**Ministry of Health and Long-Term Care**

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

**Ministère de la Santé et des Soins de longue durée**

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


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

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

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## Public Copy/Copie du public

| Report Date(s) / Date(s) du apport | Inspection No / No de l'inspection | Log # / Registre no | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Mar 13, 2017 | 2017_435621_0006 | 001621-17 | Resident Quality Inspection |

### Licensee/Titulaire de permis

BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA
1220 Valley Drive KENORA ON P9N 2W7

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

NORTHWOOD LODGE
51 Highway 105 P.O. Box 420 RED LAKE ON P0V 2M0

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

JULIE KUORIKOSKI (621), JENNIFER KOSS (616), SHEILA CLARK (617)

### Inspection Summary/Résumé de l'inspection

**The purpose of this inspection was to conduct a Resident Quality Inspection inspection.**

**This inspection was conducted on the following date(s): February 6-10, 2017**

**Logs that were inspected include:**
**One intake related to a critical incident the home submitted regarding a resident fall; and**
**One intake related to a critical incident the home submitted regarding staff to resident abuse.**

**During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Maintenance Supervisor, Activity Coordinator, Residents' Council President, Family Council President, residents and family members.**

**The Inspectors also reviewed resident health records, the home's policies and procedures, employee training records and staff files. Additionally, observations of residents, observations of provision of care and services to residents, and observations of resident and staff interactions were made by the Inspectors.**

**The following Inspection Protocols were used during this inspection:**
**Accommodation Services - Maintenance**
**Continence Care and Bowel Management**
**Dining Observation**
**Falls Prevention**
**Family Council**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Minimizing of Restraining**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Residents' Council**

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

**7 WN(s)**
**1 VPC(s)**
**1 CO(s)**
**0 DR(s)**
**0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Legendé<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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).<br><br>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.<br><br>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 was maintained in a safe condition and in a good state of repair.

During the inspection, residents #003, #005 and #006 were identified as requiring additional inspection regarding wall and floor disrepair in their rooms.

Inspectors #616 and #617 observed on two days in February 2017, the following disrepair in resident #003's room:
-a 10 foot long by three inch wide piece of wood trim, approximately 34 inches from the floor, was missing along the entire wall behind the resident's bed, with wall damage exposed;
-four small circular gouges, measuring one half inch in diameter, were observed clustered together on the top half of the wall, and to the right side of the resident's head board;
-the left corner wall, located at the entrance to the room displayed a portion of scuffed drywall just above the baseboard measuring three inches by six inches; and
-the left corner wall adjacent to the resident's closet, displayed a portion of scuffed drywall just above the baseboard measuring four inches by seven inches.

On the same two days in February 2017, Inspectors #616 and #617 observed the following disrepair in resident #005's room:
-a portion of wood trim, measuring 12 inches long by three inches wide, was observed to be damaged along the wall behind the headboard of the resident's bed;

-drywall damage measuring six inches long by three inches wide was observed on the corner of the wall to the left side of the closet; and
-a seven and one-half inch long section of baseboard was observed to be missing on the left corner wall adjacent to the closet doors.

Inspectors #621 and #617 observed on two days in February 2017, the following disrepair in resident #006's room:
-6 small circular gouges, measuring one half inch in diameter, were located along the wall behind the resident's recliner; and
-3 small circular gouges, measuring one half inch in diameter, were located along the wall behind the headboard of the resident's bed.

On the same two days in February 2017, Inspector #617 observed the following disrepair in the common resident lounge adjacent to the entrance of the home:
-scuffed drywall, measuring 18 inches long by three inches wide, was located along the wall to the left side of the doors leading to the front veranda; and
-a baseboard measuring 21 inches long, and a section of flooring measuring 21 inches long and three inches wide was missing at the bottom of the wall to the right side of the window.

Again, during the same two days in February 2017, Inspector #617 observed the following disrepair to the entrance area of the home:
-a gouge measuring two inches long by one inch wide, and another gouge measuring 13 inches long by two inches wide were located on the corners of the wall under the large wooden pillars; and
-a baseboard measuring 11 inches long and three inches wide was detached and laying along the wall beside the front entrance door.

Again on two specified days in February 2017, Inspector #617 observed the following disrepair in the main dining room:
-the wall on the left side of exit door to the patio displayed scuffed drywall measuring 16 inches by three inches;
-the metal frame of the exit door located on the exterior wall had paint missing along the entire bottom of the door and on both the right and left sides measuring 26 inches in length;
-paneling which measured 22 inches long and 11 inches wide was detached from the wall on the left side of the exit door;
-a baseboard measuring two inches long and two inches wide was missing along the left

side of the exit door; and
-a one inch long by two inch wide gouge, as well as cracked paneling surrounding the gouge in an area measuring six inches long and three inches wide was observed along the base of the corner wall located to the left side of the dining room entrance.

Inspector #617 interviewed Maintenance Supervisor #101 on a specific day in February 2017, who acknowledged and was aware of the damaged walls, baseboard, trim and flooring in several of the residents' rooms, as well as in the dining room, common rooms and front entrance. Maintenance Supervisor #101 further reported that they were waiting on funding to make the repairs.

During an interview with the Administrator on a specific day in February 2017, they confirmed that there were several areas of the home that were in disrepair, including walls and flooring and that the home was still waiting on the outcome of a funding request made to complete the improvements. [s. 15. (2) (c)] (617)

***Additional Required Actions:***

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

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**WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan**

**Specifically failed to comply with the following:**

**s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:**
**2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks. O. Reg. 79/10, s. 24 (2).**

**Findings/Faits saillants :**

1.The licensee has failed to ensure that a 24-hour admission care plan was developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home, and included, at a minimum, any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.

A Critical Incident Systems (CIS) report was submitted to the Director on a day in August 2016, related to an incident of alleged staff to resident abuse that occurred on another day in August 2016.

Inspector #616 reviewed the CIS report, which identified resident #007 allegedly sustained an injury during personal care provided by PSW #103 and PSW #104.

The Inspector reviewed resident #007's health care record which included documentation from August 2016, identifying a specific medical diagnosis. In addition, the Inspector reviewed a copy of an assessment tool, dated from June 2016, which indicated resident #007 had a specified number of responsive behaviours and outlined what interventions were successful at reducing this resident's responsive behaviours.

Inspector #616 reviewed resident #007's August 2016, written care plan, dated six days following this resident's admission, and four days after the reported incident involving the two PSW staff during care. The care plan documented interventions within two care areas specific to responsive behaviours. Additionally, the Inspector identified that a 24-hour admission care plan was not documented and part of the resident's plan of care prior to the incident.

During an interview with the Administrator on a day in February 2017, they verified to the Inspector that resident #007's care plan was created six days after the resident's admission, and that the resident did not have a 24 hour admission care plan developed which included the resident's known responsive behaviours. [s. 24. (2) 2.] (616)

***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 a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home, and include at a minimum, any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks, to be implemented voluntarily.***

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**WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the menu cycle was reviewed by the Residents' Council.

Inspector #617 reviewed copies of the monthly Residents' Council meeting minutes provided by the home between March and November 2016, and noted that there was no documentation identifying that Residents' Council had reviewed the home's menu cycle.

During an interview with the Administrator and Activity Coordinator #106, they identified to the Inspector that the Residents' Council had not elected a president but that resident #010 was a member of the council who regularly attended the monthly meetings over the past year, and was an active participant and knowledgeable to the concerns and/or recommendations raised.

On a day in February 2017, Inspector #617 interviewed resident #010 who reported that they had attended meetings of Residents' Council over the past year, and identified that the home had not provided a copy of the home's menu cycle for Residents' Council to review during that time.

During an interview on a subsequent day in February 2017, with the Administrator, they verified to Inspector #617 that the menu cycle had not been reviewed by the Residents' Council over the past year. [s. 71. (1) (f)] (617)

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**WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 79. Posting of information**

**Specifically failed to comply with the following:**

**s. 79. (3) The required information for the purposes of subsections (1) and (2) is,**
**(a) the Residents' Bill of Rights; 2007, c. 8, s. 79 (3)**
**(b) the long-term care home's mission statement; 2007, c. 8, s. 79 (3)**
**(c) the long-term care home's policy to promote zero tolerance of abuse and neglect of residents; 2007, c. 8, s. 79 (3)**
**(d) an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 79 (3)**
**(e) the long-term care home's procedure for initiating complaints to the licensee; 2007, c. 8, s. 79 (3)**
**(f) the written procedure, provided by the Director, for making complaints to the Director, together with the name and telephone number of the Director, or the name and telephone number of a person designated by the Director to receive complaints; 2007, c. 8, s. 79 (3)**
**(g) notification of the long-term care home's policy to minimize the restraining of residents, and how a copy of the policy can be obtained; 2007, c. 8, s. 79 (3)**
**(h) the name and telephone number of the licensee; 2007, c. 8, s. 79 (3)**
**(i) an explanation of the measures to be taken in case of fire; 2007, c. 8, s. 79 (3)**
**(j) an explanation of evacuation procedures; 2007, c. 8, s. 79 (3)**
**(k) copies of the inspection reports from the past two years for the long-term care home; 2007, c. 8, s. 79 (3)**
**(l) orders made by an inspector or the Director with respect to the long-term care home that are in effect or that have been made in the last two years; 2007, c. 8, s. 79 (3)**
**(m) decisions of the Appeal Board or Divisional Court that were made under this Act with respect to the long-term care home within the past two years; 2007, c. 8, s. 79 (3)**
**(n) the most recent minutes of the Residents' Council meetings, with the consent of the Residents' Council; 2007, c. 8, s. 79 (3)**
**(o) the most recent minutes of the Family Council meetings, if any, with the consent of the Family Council; 2007, c. 8, s. 79 (3)**
**(p) an explanation of the protections afforded under section 26; 2007, c. 8, s. 79 (3)**
**(q) any other information provided for in the regulations. 2007, c. 8, s. 79 (3)**

**Findings/Faits saillants :**

1. The home has failed to ensure that the required information for the purposes of subsections (1) and (2), copies of the inspection reports from the past two years for the long-term care home was posted in the home.

During the inspection, Inspector #617 conducted a tour of the home on a specified day in February 2017, and it was identified that a specific public inspection report was missing from the postings on the bulletin board at the entrance into the nursing unit.

On three subsequent days in February 2017, Inspector #617 observed that the same public inspection report for a specified inspection continued to be missing and not posted on the bulletin board with the other inspection reports.

During an interview on a day in February 2017, the Administrator confirmed to the Inspector that a copy of the identified public inspection report was not posted on the bulletin board. [s. 79. (3) (k)] (617)

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**WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey**

**Specifically failed to comply with the following:**

**s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the advice of the Family Council, if any, was sought in developing and carrying out the survey, and in acting on its results.

During an interview with the Family Council President on a day in February 2017, they reported to Inspector #621 that the home had not sought the advice of Family Council over the past year related to the development and carrying out of the annual satisfaction survey, and in acting on its results.

Inspector #621 reviewed copies of the Family Council meeting minutes provided by the home over the previous year between April and November 2016, and noted that there

was no documentation identifying that the home had sought out the advice of Family Council in development and carrying out the satisfaction survey.

During an interview with the Administrator on another day in February 2017, they confirmed to the Inspector that the home had not sought the advice of Family Council over the past year in developing and carrying out the satisfaction survey and acting on its results. [s. 85. (3)] (621)

2. The licensee has failed to seek the advice of the Residents' Council, if any, in developing and carrying out the satisfaction survey, and in acting on its results.

Inspector #617 reviewed copies of the monthly Residents' Council meeting minutes provided by the home from March to November 2016, and noted that there was no documentation identifying that the home had sought out the advice of the council in developing and carrying out the satisfaction survey.

During an interview with the Administrator and Activity Coordinator #106, they reported to the Inspector that the Residents' Council had not elected a president but that resident #010 was an active participant who had regularly attended monthly meetings over the past year, and could speak to activities of Residents' Council.

On a specific day in February 2017, Inspector #617 interviewed resident #010, who reported that they had attended the Residents' Council meeting over the past year, and during this time, the home had not sought out the advice of the Residents' Council for the development and carrying out of the satisfaction survey.

During interviews with the Administrator and Activity Coordinator #106 on the same day in February 2017, they confirmed to the Inspector that the home had not sought the advice of Residents' Council over the past year in developing and carrying out the satisfaction survey and acting on its results. [s. 85. (3)] (617)

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**WN #6: 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. (5) The licensee shall ensure that the resident's substitute decision-maker, if any, or any person designated by the substitute decision-maker and any other person designated by the resident are promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who are to be so notified. O. Reg. 79/10, s. 107 (5).**

**Findings/Faits saillants :**

1.The licensee has failed to ensure that the resident's substitute decision-maker, if any or any person designated by the substitute decision-maker and any other person designated by the resident were promptly notified of a serious injury or serious illness of the resident, in accordance with any instructions provided by the person or persons who were to be so notified. O. Reg.79/10, s.107(5)

A Critical Incident System (CIS) report was submitted to the Director for an incident that occurred on a specific day in May 2016, where resident #009 fell and sustained an injury. It was identified in the CIS report that the substitute decision maker (SDM) had not been notified of the incident until the resident returned from hospital two days later.

During an interview with the Administrator on a day in February 2017, they reported that it was their expectation that registered staff on duty contacted the SDM immediately concerning incidents that resulted in significant change to a residents' status. The Administrator identified to the Inspector that there had been miscommunication between RPN #105 and themselves regarding who would take responsibility of contacting resident #009's SDM following the incident on the specified day in May 2016, and that a decision had been made by the Administrator to wait until the day shift on the same day to contact the SDM. The Administrator further reported that they discovered after the resident had returned from hospital two days later, that the SDM had not been notified of the fall, or of the home sending the resident to hospital. The Administrator reported to the Inspector that they ensured the SDM was notified as soon as they discovered the omission. [s. 107. (5)] (621)

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 228. Continuous quality improvement**

**Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:**

**1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.**

**2. The system must be ongoing and interdisciplinary.**

**3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.**

**4. A record must be maintained by the licensee setting out,**

**i. the matters referred to in paragraph 3,**

**ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and**

**iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.**

**Findings/Faits saillants :**

1.The licensee has failed to ensure that improvements made through the home's quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents was communicated to the Residents' Council.

Inspector #617 reviewed copies of the monthly Residents' Council meeting minutes provided by the home from March to November 2016, and noted that there was no documentation that improvements made to the home's quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents was communicated to the Residents' Council.

During an interview on a specific day in February 2017, with the Administrator and Activity Coordinator #106, they identified to the Inspector that the Residents' Council had not elected a president but that resident #010 was a member of the council who regularly attended monthly meetings over the past year, and was an active participant and knowledgeable to the concerns and/or recommendations raised.

On the same day in February 2017, Inspector #617 interviewed resident #010, who reported that they had attended Residents' Council meetings over the past year, and they were not aware of any communications over that time from the home regarding improvements made through the home's quality improvement and utilization review system to accommodations, care, services, programs, and goods provided to the residents.

During an interview with the Administrator later on a specific day in February 2017, they confirmed to the Inspector that improvements made through the quality improvement and utilization review system to care, services, programs and goods provided to the residents over the past year had not been communicated to the Residents’ Council. [s. 228. 3.] (617)

**Issued on this 20th day of March, 2017**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Health and Long-Term Care**

**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

**Ministére de la Santé et des Soins de longue durée**

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

**Division des foyers de soins de longue durée**
**Inspection de soins de longue durée**

## Public Copy/Copie du public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | JULIE KUORIKOSKI (621), JENNIFER KOSS (616), SHEILA CLARK (617) |
| **Inspection No. / No de l'inspection :** | 2017_435621_0006 |
| **Log No. / Registre no:** | 001621-17 |
| **Type of Inspection / Genre d'inspection:** | Resident Quality Inspection |
| **Report Date(s) / Date(s) du Rapport :** | Mar 13, 2017 |
| **Licensee / Titulaire de permis :** | BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA<br>1220 Valley Drive, KENORA, ON, P9N-2W7 |
| **LTC Home / Foyer de SLD :** | NORTHWOOD LODGE<br>51 Highway 105, P.O. Box 420, RED LAKE, ON, P0V-2M0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Kandice Henry |

To BOARD OF MANAGEMENT OF THE DISTRICT OF KENORA, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Health and Long-Term Care**

**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

**Ministére de la Santé et des Soins de longue durée**

**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 # / Ordre no :** 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 shall ensure that cosmetic fixes in resident rooms and common areas, including but not limited to, drywall repairs, painting, baseboard and trim repairs, and repair or replacement of missing flooring are addressed.

**Grounds / Motifs :**

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

During the inspection, residents #003, #005 and #006 were identified as requiring additional inspection regarding wall and floor disrepair in their rooms.

Inspectors #616 and #617 observed on two days in February 2017, the following disrepair in resident #003's room:
-a 10 foot long by three inch wide piece of wood trim, approximately 34 inches from the floor, was missing along the entire wall behind the resident's bed, with wall damage exposed;
-four small circular gouges, measuring one half inch in diameter, were observed clustered together on the top half of the wall, and to the right side of the resident's head board;
-the left corner wall, located at the entrance to the room displayed a portion of scuffed drywall just above the baseboard measuring three inches by six inches; and
-the left corner wall adjacent to the resident's closet, displayed a portion of

scuffed drywall just above the baseboard measuring four inches by seven inches.

On the same two days in February 2017, Inspectors #616 and #617 observed the following disrepair in resident #005's room:
-a portion of wood trim, measuring 12 inches long by three inches wide, was observed to be damaged along the wall behind the headboard of the resident's bed;
-drywall damage measuring six inches long by three inches wide was observed on the corner of the wall to the left side of the closet; and
-a seven and one-half inch long section of baseboard was observed to be missing on the left corner wall adjacent to the closet doors.

Inspectors #621 and #617 observed on two days in February 2017, the following disrepair in resident #006's room:
-6 small circular gouges, measuring one half inch in diameter, were located along the wall behind the resident's recliner; and
-3 small circular gouges, measuring one half inch in diameter, were located along the wall behind the headboard of the resident's bed.

On the same two days in February 2017, Inspector #617 observed the following disrepair in the common resident lounge adjacent to the entrance of the home:
-scuffed drywall, measuring 18 inches long by three inches wide, was located along the wall to the left side of the doors leading to the front veranda; and
-a baseboard measuring 21 inches long, and a section of flooring measuring 21 inches long and three inches wide was missing at the bottom of the wall to the right side of the window.

Again, during the same two days in February 2017, Inspector #617 observed the following disrepair to the entrance area of the home:
-a gouge measuring two inches long by one inch wide, and another gouge measuring 13 inches long by two inches wide were located on the corners of the wall under the large wooden pillars; and
-a baseboard measuring 11 inches long and three inches wide was detached and laying along the wall beside the front entrance door.

Again on two specified days in February 2017, Inspector #617 observed the following disrepair in the main dining room:
-the wall on the left side of exit door to the patio displayed scuffed drywall

measuring 16 inches by three inches;
-the metal frame of the exit door located on the exterior wall had paint missing along the entire bottom of the door and on both the right and left sides measuring 26 inches in length;
-paneling which measured 22 inches long and 11 inches wide was detached from the wall on the left side of the exit door;
-a baseboard measuring two inches long and two inches wide was missing along the left side of the exit door; and
-a one inch long by two inch wide gouge, as well as cracked paneling surrounding the gouge in an area measuring six inches long and three inches wide was observed along the base of the corner wall located to the left side of the dining room entrance.

Inspector #617 interviewed Maintenance Supervisor #101 on a specific day in February 2017, who acknowledged and was aware of the damaged walls, baseboard, trim and flooring in several of the residents' rooms, as well as in the dining room, common rooms and front entrance. Maintenance Supervisor #101 further reported that they were waiting on funding to make the repairs.

During an interview with the Administrator on a specific day in February 2017, they confirmed that there were several areas of the home that were in disrepair, including walls and flooring and that the home was still waiting on the outcome of a funding request made to complete the improvements. [s. 15. (2) (c)] (617)

The decision to issue this compliance order was based on the scope of this issue which was a pattern wall and floor damage in resident rooms and home areas, the severity which indicated minimum risk; and the compliance history which identified the licensee has a history of non-compliance with s.15 of the LTCHA, 2007. Since 2014, the section has been issued two previous times with a voluntary plan of correction issued during Resident Quality Inspection 2014_211106_0006; and a second voluntary plan of correction issued during Resident Quality Inspection 2016_433625_0010. (617)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Apr 28, 2017

## 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 or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 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
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and 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 SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

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

La demande de réexamen doit contenir ce qui suit :

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

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Inspection de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

**Issued on this 13th day of March, 2017**

**Signature of Inspector /**
**Signature de l'inspecteur :**

**Name of Inspector /**
**Nom de l'inspecteur :** Julie Kuorikoski

**Service Area Office /**
**Bureau régional de services :** Sudbury Service Area Office