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 prévue 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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159 rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Apr 30, 2019	2019_616722_0007 (A1)	031683-18	Follow up

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

Princess Court
Princess Street Box 725 DRYDEN ON P8N 2Z4

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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance due date on the licensee inspection report was amended from May 31, 2019, to July 1, 2019, to provide the licensee with 60 days to comply the order.

Issued on this 30th day of April, 2019 (A1)

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

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

Ministère de la Santé et des Soins de longue durée

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

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Princess Street Box 725 DRYDEN ON P8N 2Z4

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

Amended by COREY GREEN (722) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): April 24 and 25, 2019.

The following intake was inspected:

One (1) log to follow-up compliance order (CO) #001 related to resident plans of care, re-issued on February 8, 2019, during follow-up inspection #2018_703625_0023, with a compliance due date (CDD) of March 8, 2019. CO #001 related to plan of care was initially issued to the licensee on January 17, 2018, during inspection #2017_435621_0026, with a CDD of March 30, 2018.

During the course of the inspection, the inspector(s) spoke with residents, clerical staff, a dietary aide (DA), personal support workers (PSWs), registered practical nurses (RPNs), registered nurses (RNs), the RAI-MDS Coordinator, registered dietician (RD), assistant director of care (ADOC), director of care (DOC), and District Administrator.

Observations were made of residents, resident-to-staff interactions, and resident home areas. Select resident health records were reviewed, including care plans, progress notes, and other relevant records. Administrative records were reviewed, including staff schedules, email correspondence, health record audit documentation, and staff training material and participation lists.

The following Inspection Protocols were used during this inspection:

Falls Prevention
Nutrition and Hydration

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

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

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (7)	CO #001	2018_703625_0023	722

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. 212. Administrator

Specifically failed to comply with the following:

s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Findings/Faits saillants :

The licensee failed to ensure that, in a home with a licensed bed capacity of 97 beds or more, the home's Administrator works regularly in that position on site at the home at least 35 hours per week.

On entry to the home for this inspection, Inspector #722 was informed by the home's Administrative Secretary, staff #104, that the home's Administrator had been absent for a specified period of time, and they were not sure when the Administrator was expected to return.

Inspector #722 interviewed RPN #103, who also indicated that the Administrator had not been present in the home for a specified period, but were unsure of the dates that the Administrator was absent, and did not know when the Administrator was expected to return to work. The RPN indicated that they believed that the DOC was covering for the Administrator, but they were not certain.

The DOC was interviewed by Inspector #722, and indicated that the Administrator had been absent from the home since an identified date, for specified reasons. The DOC indicated that the Administrator returned to work for several specified days, and has been absent from the home since that time. The DOC confirmed that there were 97 licensed beds in the home, and that all of their time was dedicated to their DOC duties. They also indicated that they were not the acting Administrator; and confirmed that they did not have the required qualifications to cover the Administrator position.

Inspector #722 reviewed email correspondence sent by the Administrator to the District Administrator for Kenora District Homes for the Aged, and the DOC. Three email messages were sent on identified dates, which indicated that the Administrator would be away from the home for specified reasons and specified periods of time. The final message indicated an anticipated date of return; however, as indicated above by the DOC, the Administrator returned for a specified number of days, and was absent since that time.

Inspector #722 interviewed the District Administrator, who confirmed that the Administrator had been absent from the home since an identified date, for specified reasons, and that the expectation was that the Administrator would be returning to the home to continue with their duties. They confirmed that the home had 97 licensed beds; and that the Administrator was expected to be present and working in the home Monday to Friday, for a minimum of 35 hours each week, as per the legislation. The District Administrator also indicated that they had not been

in the home to cover for the Administrator during their absence, and acknowledged that they had not specifically informed the DOC that they were covering for the Administrator. The District Administrator was also aware that the DOC did not have the required qualifications to cover for the Administrator.

The licensee failed to ensure that the Administrator worked regularly in that position on site at the home for at least 35 hours per week since January 28, 2019. [s. 212. (1) 3.]

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 001

Issued on this 30th day of April, 2019 (A1)

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

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by COREY GREEN (722) - (A1)
Inspection No. / No de l'inspection :	2019_616722_0007 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	031683-18 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Apr 30, 2019(A1)
Licensee / Titulaire de permis :	Board of Management of the District of Kenora 1220 Valley Drive, KENORA, ON, P9N-2W7
LTC Home / Foyer de SLD :	Princess Court Princess Street, Box 725, DRYDEN, ON, P8N-2Z4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Patrick Berrey

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:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 212. (1) 3., specifically:

The licensee shall ensure that there is a qualified Administrator, or acting Administrator, working at least 35 hours per week in the home.

Grounds / Motifs :

1. The licensee failed to ensure that, in a home with a licensed bed capacity of 97 beds or more, the home's Administrator works regularly in that position on site at the home at least 35 hours per week.

On entry to the home for this inspection, Inspector #722 was informed by the home's Administrative Secretary, staff #104, that the home's Administrator had been absent for a specified period of time, and they were not sure when the Administrator was expected to return.

Inspector #722 interviewed RPN #103, who also indicated that the Administrator had not been present in the home for a specified period, but were unsure of the dates that the Administrator was absent, and did not know when the Administrator was

expected to return to work. The RPN indicated that they believed that the DOC was covering for the Administrator, but they were not certain.

The DOC was interviewed by Inspector #722, and indicated that the Administrator had been absent from the home since an identified date, for specified reasons. The DOC indicated that the Administrator returned to work for several specified days, and has been absent from the home since that time. The DOC confirmed that there were 97 licensed beds in the home, and that all of their time was dedicated to their DOC duties. They also indicated that they were not the acting Administrator; and confirmed that they did not have the required qualifications to cover the Administrator position.

Inspector #722 reviewed email correspondence sent by the Administrator to the District Administrator for Kenora District Homes for the Aged, and the DOC. Three email messages were sent on identified dates, which indicated that the Administrator would be away from the home for specified reasons and specified periods of time. The final message indicated an anticipated date of return; however, as indicated above by the DOC, the Administrator returned for a specified number of days, and was absent since that time.

Inspector #722 interviewed the District Administrator, who confirmed that the Administrator had been absent from the home since an identified date, for specified reasons, and that the expectation was that the Administrator would be returning to the home to continue with their duties. They confirmed that the home had 97 licensed beds; and that the Administrator was expected to be present and working in the home Monday to Friday, for a minimum of 35 hours each week, as per the legislation. The District Administrator also indicated that they had not been in the home to cover for the Administrator during their absence, and acknowledged that they had not specifically informed the DOC that they were covering for the Administrator. The District Administrator was also aware that the DOC did not have the required qualifications to cover for the Administrator.

The licensee failed to ensure that the Administrator worked regularly in that position on site at the home for at least 35 hours per week since January 28, 2019. [s. 212. (1) 3.]

The severity of this issue was determined to be a level 2 as staffing is a Key Risk

Indicator and there was risk of harm to the residents. The scope of the issue was a level 3 (widespread), as it related to all residents in the home. The home had a level 2 history of non-compliance, with no previous non-compliance related to this section of O.Reg. 79/10. (722)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 01, 2019(A1)

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 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, 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 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 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 de la Santé et 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 de la Santé et 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 30th day of April, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by COREY GREEN (722) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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

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