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

Central East Service Area Office
419 King Street West Suite #303
OSHAWA ON L1J 2K5
Telephone: (905) 433-3013
Facsimile: (905) 433-3008

Bureau régional de services du Centre-Est
419 rue King Ouest bureau 303
OSHAWA ON L1J 2K5
Téléphone: (905) 433-3013
Télécopieur: (905) 433-3008

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
May 17, 2019	2019_414110_0001 (A1)	026359-17, 001078-18, 011507-18	Complaint

Licensee/Titulaire de permis

City of Toronto
365 Bloor Street East 15th Floor TORONTO ON M4W 3L4

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

Seven Oaks
9 Neilson Road SCARBOROUGH ON M1E 5E1

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

Amended by DIANE BROWN (110) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

On May 16, 2019 Administrator Peter Puiatti requested an extension to the compliance order from the May 31, 2019 deadline to June 30, 2019 related to the home being in outbreak 3 times over the course of March and April and delaying the completion all the requirements.

Issued on this 17th day of May, 2019 (A1)

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

Original report signed by the inspector.

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

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

Amended by DIANE BROWN (110) - (A1)

Amended 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): January 2, 3, 4, 7, 8, 9, 10, 11, 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 30, 2019.

During the inspection the following was completed

Complaint log #1 related to an allegation of staff to resident abuse.

Complaint log #2related to an allegation of staff to resident abuse and medication administration.

Complaint log #3 related to an allegation of resident to resident abuse and responsive behaviors.

Critical Incident #4 related to an allegation of staff to resident abuse.

A Compliance Order related to O. Reg. 79/10, s. 101 (2) , identified in concurrent inspection report #2019_486653_0004 (Log #s: 009354-17, 009967-17) will be issued in this report.

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Nursing, Nurse Managers Operational, Nurse Manager Clinical, Social Workers, Registered Nursing Staff, Personal Care Aide, Behavioral Support Worker, Housekeeper.

The following Inspection Protocols were used during this inspection:

Dignity, Choice and Privacy
Medication
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours

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

- **2 WN(s)**
- **1 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. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record is kept in the home that includes (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant.

A complaint was received by the Ministry of Health and Long Term Care, on an identified date, whereby complainant, resident #001, expressed concerns, had reported them to management and had not received a response.

An interview with resident #001 revealed the expressing concerns to management by way of speaking with or leaving a voice mail message for identified staff. The interview revealed that the resident had expressed concerns identified as concern #1, #2 and #3.

A review of the resident's progress notes over a five month period failed to identify documentation related to the resident's concerns.

A record review of the home's complaint binder for 2017 and 2018 failed to identify any logged complaints received by resident #001.

An interview PCA #111 identified that resident #001 had voiced complaints around concern #1.

An interview with RN #100 shared that resident #001 had complained about concern #2.

An interview with PCA #113 stated that resident #001 complains all the time about the home and resident stated the home was not doing anything about their concerns.

An interview with RPN #112 stated a staff, however unable to recall the staffs name, reported to them that the resident had a concern related to issue #2. When asked if this complaint was investigated RPN #112 shared that it was related to resident #001's behaviours.

An interview with Social Worker #118 revealed that most of resident #001's concerns were related to concern #3 and that the resident had been voicing this concern for years. The SW further stated that resident #001 does leave many voice mail messages and had expressed concerns around issue #2

An interview with Nurse Manager Operational #105 revealed that if a PSW or registered staff receive a complaint regarding care or services they document in the progress notes and depending on the severity of the concern it would get documented in the 24 hour report. The NM stated that registered staff would try and deal with it and make a note in the progress note or 24 hour report depending on the nature of the complaint. The NM that depending on the nature of the concern issues are brought forward from the 24 hrs report to be discussed at the morning management meeting. The NM stated that the Administrator would log the concerns discussed. The NM revealed that they document in the progress note when they receive a significant complaint. When asked if any concerns have been brought forward by resident #001 NM shared that they had expressed concern related to issue #1. NM stated their response to resident #001 was asking them what they would like them to do about it. NM shared that for as long as they have been there resident #001 has complained about concern #3.

A record review of the home's policy entitled Managing and Reporting Complaints AD-0515-00 Section 05-Information and Privacy
Published 01-04-2016 included the following:

If you are unable to resolve the complaint thank the complainant for bringing it to your attention and advise the complainant which manager you will be forwarding their complaint to. Advise the manager of the complaint.
Immediately initiate an investigation of the complaint including date, time, location, witness and submit to immediate supervisor.
All complaints need to be logged, regardless of whether they are verbal or in writing.

An interview with the Administrator shared that most of the complaints go through the nurse or the nurse manager they have the ability to resolve it and follow up with the complaint. The manager will say to me a verbal complaint came up and it has been three days and hasn’t been resolved. If it’s been over 24 hours we will log it. The administrator shared that resident #001 does express concerns to them but that they try and deal with it within 24 hours.

The licensee failed to ensure that a documented record is kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant, for the complaints they received from resident #001. [s. 101. (2)]

2. As a result of non-compliance being identified related to resident #001 and the complaint process the sample size was expanded by two additional residents including resident #011.

During an interview resident #011 shared with Inspector #746 that they had brought forward two concerns over an identified time period, to which they had not received a response. The resident expressed both concerns and are identified as concern #1 and #2. The resident identified they had spoken with SW #118 who shared they would communicate to Clinical Nurse Manager #103. The resident further stated that Nurse manager #103 had spoken with them and asked them if they would be willing to verify the statements to which the resident agreed. Resident #011 shared that they never heard back from anyone including Clinical Nurse Manager #103.

A record review of the resident's progress notes over an identified six month

period failed to identify any concerns raised by the resident.

A review of the 2018 complaint binder failed to identify any concerns brought forward by resident #011.

An interview with SW #118 confirmed that resident #011 had brought forward a concern about issue #2 but not issue #1. The SW shared that they passed along a message to Nurse Manager #103 that resident #011 was upset and asked them to speak with them.

An interview with Clinical Nurse Manager (CNM) #103 revealed that the manager of the unit would investigate complaints and respond back to the complainant and document in the resident's progress notes. The CNM shared they did not recall hearing from SW #118 that resident #011 had reported concerns #1 and #2 The CNM shared that the SW did bring forward another concern of resident #011 that they had followed up with the resident in this regard and communicated the concern to Nurse Manager Operational (NMO) #117.

An interview with Nurse Manager Operational #117 shared that whoever received the resident complaint was responsible for following up with the resident. Inspectors #110 and #746 shared resident #011's concerns. The Nurse Manager stated it was the first time hearing of resident #011's concerns. [s. 101. (2)]

3. A complaint inspection, report #2019_486653_0004 related to complaints identified log #(s) was conducted concurrently by Inspector #653 which expanded the sample size to three residents/SDM.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline had received a complaint on an identified date related to resident #009's preferences and care needs.

A review of resident #009's health records revealed they had been admitted to the home on an identified date and discharged months later.

An interview with PSW #134 on February 4, 2019, at 0930hrs, indicated they recalled resident #009's family had complained about concern #1 and that they had raised a number of concerns.

An interview with Social Worker (SW) #131 on February 1, 2019, at 0850hrs,

indicated they remember resident #009's family making numerous complaints. The SW stated that resident #009's family member communicated constantly to Previous Nurse Manager Operational (PNMO) #137. The SW further indicated the resident's family member had expressed concern around issue #1.

A telephone interview with PNMO #137 on February 4, 2019, at 1337hrs, indicated they recalled receiving concerns from resident #009's family member. The PNMO stated they would have documented on the concerns and complaints forms and placed it in a black binder kept in their previous office in the home.

A review of resident #009's family member's correspondence with the home revealed the following:
-On an identified date , resident #009's family member had sent correspondence addressed to the home's previous Administrator carbon copied to PNMO #137, the Assistant Administrator, and the DON. The e-mail had outlined concerns pertaining to resident #009's care needs.
-On a separate identified date resident #009's family member had sent correspondence addressed to PNMO #137, outlining concerns they had identified during their visit to the resident in the home on an identified date.
-On a separate identified date, resident #009's family member had sent correspondence addressed to PNMO #137, outlining concerns they had identified during their visit to the resident in the home on an identified date.

During the course of the inspection, Inspector #653 reviewed the home's 2017 complaints binder and did not find any documented record of complaints pertaining to resident #009. NMO #117 also searched for PNMO #137's concerns and complaints black binder, however, they did not find it.

As per record reviews and staff interviews, the home was unable to provide evidence that a documented record was kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, for the complaints they had received from resident #009's family member. [s. 101. (2)]

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

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure when a resident is reassessed and the plan of care reviewed and revised if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care.

A record review of resident #001's written plan of care identified a statement of resident #001's psychosocial well-being with goals and related to factors and interventions.

An interview with resident #001 expressed concern with their psychosocial well-being in the home related to staff comments.

An interview with PCA #111, PCA #113 and NM #105 shared comments that would not in support of residents psychosocial well-being plan of care.

An interview with SW #118 shared an unawareness that staff have made comments and that these conversations would not meet the resident's psychosocial needs and could make the resident feel unwelcome in the home. The SW shared the resident's written plan of care related to their psychosocial needs had not been reviewed and revised with different approaches considered in the revision of the plan of care and that the current plan of care was not effective in meeting the resident's psychosocial needs. [s. 6. (11) (b)]

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 when a resident is reassessed and the plan of care reviewed and revised if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care, to be implemented voluntarily.

Issued on this 17th day of May, 2019 (A1)

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

Original report signed by the inspector.

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

Ministère 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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by DIANE BROWN (110) - (A1)
Inspection No. / No de l'inspection :	2019_414110_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	026359-17, 001078-18, 011507-18 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	May 17, 2019(A1)
Licensee / Titulaire de permis :	City of Toronto 365 Bloor Street East, 15th Floor, TORONTO, ON, M4W-3L4
LTC Home / Foyer de SLD :	Seven Oaks 9 Neilson Road, SCARBOROUGH, ON, M1E-5E1
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Peter Puiatti

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To City of Toronto, 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. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint;
(b) the date the complaint was received;
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
(d) the final resolution, if any;
(e) every date on which any response was provided to the complainant and a description of the response; and
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, r. 101. (2)

The licensee is ordered to:
1. The process of documenting the nature of each verbal or written complaint including those complaints from residents shall be clarified and communicated with all staff. Roles and responsibilities for documenting, investigating and responding to complainants shall be shared. A record of education and staff participation shall be maintained.
2. The administrator shall meet with all Nursing Managers and the DOC to log all verbal or written complaints, including resident complaints, received and not logged, within the last 3 months.
3. Each logged complaint shall include a record of (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant.
4. A record shall be kept of steps 1-3 for review by the Inspector.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that a documented record is kept in the home that includes (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant.

A complaint was received by the Ministry of Health and Long Term Care, on an identified date, whereby complainant, resident #001, expressed concerns, had reported them to management and had not received a response.

An interview with resident #001 revealed the expressing concerns to management by way of speaking with or leaving a voice mail message for identified staff. The interview revealed that the resident had expressed concerns identified as concern #1, #2 and #3.

A review of the resident's progress notes over a five month period failed to identify documentation related to the resident's concerns.

A record review of the home's complaint binder for 2017 and 2018 failed to identify any logged complaints received by resident #001.

An interview PCA #111 identified that resident #001 had voiced complaints around concern #1.

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An interview with PCA #113 stated that resident #001 complains all the time about the home and resident stated the home was not doing anything about their concerns.

An interview with RPN #112 stated a staff, however unable to recall the staffs name, reported to them that the resident had a concern related to issue #2. When asked if this complaint was investigated RPN #112 shared that it was related to resident #001's behaviours.

An interview with Social Worker #118 revealed that most of resident #001's concerns were related to concern #3 and that the resident had been voicing this concern for years. The SW further stated that resident #001 does leave many voice mail messages and had expressed concerns around issue #2

An interview with Nurse Manager Operational #105 revealed that if a PSW or registered staff receive a complaint regarding care or services they document in the progress notes and depending on the severity of the concern it would get documented in the 24 hour report. The NM stated that registered staff would try and deal with it and make a note in the progress note or 24 hour report depending on the nature of the complaint. The NM that depending on the nature of the concern issues are brought forward from the 24 hrs report to be discussed at the morning management meeting. The NM stated that the Administrator would log the concerns discussed. The NM revealed that they document in the progress note when they receive a significant complaint. When asked if any concerns have been brought

forward by resident #001 NM shared that they had expressed concern related to issue #1. NM stated their response to resident #001 was asking them what they would like them to do about it. NM shared that for as long as they have been there resident #001 has complained about concern #3.

A record review of the home's policy entitled Managing and Reporting Complaints AD-0515-00 Section 05-Information and Privacy
Published 01-04-2016 included the following:
If you are unable to resolve the complaint thank the complainant for bringing it to your attention and advise the complainant which manager you will be forwarding their complaint to. Advise the manager of the complaint.
Immediately initiate an investigation of the complaint including date, time, location, witness and submit to immediate supervisor.
All complaints need to be logged, regardless of whether they are verbal or in writing.

An interview with the Administrator shared that most of the complaints go through the nurse or the nurse manager they have the ability to resolve it and follow up with the complaint. The manager will say to me a verbal complaint came up and it has been three days and hasn't been resolved. If it's been over 24 hours we will log it. The administrator shared that resident #001 does express concerns to them but that they try and deal with it within 24 hours.

The licensee failed to ensure that a documented record is kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any (e) every date on which any response was provided to the complainant and a description of the response, and (f) any response made by the complainant, for the complaints they received from resident #001. [s. 101. (2)]

2. As a result of non-compliance being identified related to resident #001 and the complaint process the sample size was expanded by two additional residents including resident #011.

During an interview resident #011 shared with Inspector #746 that they had brought forward two concerns over an identified time period, to which they had not received a

response. The resident expressed both concerns and are identified as concern #1 and #2. The resident identified they had spoken with SW #118 who shared they would communicate to Clinical Nurse Manager #103. The resident further stated that Nurse manager #103 had spoken with them and asked them if they would be willing to verify the statements to which the resident agreed.   Resident #011 shared that they never heard back from anyone including Clinical Nurse Manager #103.

A record review of the resident's progress notes over an identified six month period failed to identify any concerns raised by the resident.

A review of the 2018 complaint binder failed to identify any concerns brought forward by resident #011.

An interview with SW #118 confirmed that resident #011 had brought forward a concern about issue #2 but not issue #1. The SW shared that they passed along a message to Nurse Manager #103 that resident #011 was upset and asked them to speak with them.

An interview with Clinical Nurse Manager (CNM) #103 revealed that the manager of the unit would investigate complaints and respond back to the complainant and document in the resident's progress notes. The CNM shared they did not recall hearing from SW #118 that resident #011 had reported concerns #1 and #2 The CNM shared that the SW did bring forward another concern of resident #011 that they had followed up with the resident in this regard and communicated the concern to Nurse Manager Operational (NMO) #117.

An interview with Nurse Manager Operational #117 shared that whoever received the resident complaint was responsible for following up with the resident. Inspectors #110 and #746 shared resident #011's concerns. The Nurse Manager stated it was the first time hearing of resident #011's concerns. [s. 101. (2)]

3. A complaint inspection, report #2019_486653_0004 related to complaints identified log #(s) was conducted concurrently by Inspector #653 which expanded the sample size to three residents/SDM.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline had received a complaint on an identified date related to resident #009's preferences and care

needs.

A review of resident #009's health records revealed they had been admitted to the home on an identified date and discharged months later.

An interview with PSW #134 on February 4, 2019, at 0930hrs, indicated they recalled resident #009's family had complained about concern #1 and that they had raised a number of concerns.

An interview with Social Worker (SW) #131 on February 1, 2019, at 0850hrs, indicated they remember resident #009's family making numerous complaints. The SW stated that resident #009's family member communicated constantly to Previous Nurse Manager Operational (PNMO) #137. The SW further indicated the resident's family member had expressed concern around issue #1.

A telephone interview with PNMO #137 on February 4, 2019, at 1337hrs, indicated they recalled receiving concerns from resident #009's family member. The PNMO stated they would have documented on the concerns and complaints forms and placed it in a black binder kept in their previous office in the home.

A review of resident #009's family member's correspondence with the home revealed the following:
-On an identified date , resident #009's family member had sent correspondence addressed to the home's previous Administrator carbon copied to PNMO #137, the Assistant Administrator, and the DON. The e-mail had outlined concerns pertaining to resident #009's care needs.
-On a separate identified date resident #009's family member had sent correspondence addressed to PNMO #137, outlining concerns they had identified during their visit to the resident in the home on an identified date.
-On a separate identified date, resident #009's family member had sent correspondence addressed to PNMO #137, outlining concerns they had identified during their visit to the resident in the home on an identified date.

During the course of the inspection, Inspector #653 reviewed the home's 2017 complaints binder and did not find any documented record of complaints pertaining to resident #009. NMO #117 also searched for PNMO #137's concerns and complaints black binder, however, they did not find it.

As per record reviews and staff interviews, the home was unable to provide evidence that a documented record was kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, for the complaints they had received from resident #009's family member. [s. 101. (2)]

(110)

2. As a result of non-compliance being identified related to resident #001 and the complaint process the sample size was expanded by two additional residents including resident #011.

During an interview resident #011 shared with Inspector #746 that they had brought forward two concerns in the summer and fall of 2018, to which they had not received a response. The resident identified the one incident that while in the hallway on nights assisting their unsteady roommate to prevent their fall they screamed out loud for help to a PCA who saw them struggling with the roommate and was ignored. The other incident was a concern that one evening a male night nurse had not taken their vitals and blood sugar as required. The resident identified they had spoken with SW #118 who shared they would communicate to Clinical Nurse Manager #103. The resident further stated that Nurse manager #103 had spoken with them and asked them if they would be willing to verify the statements to which the resident agreed. Resident #011 shared that they never heard back from anyone including Clinical Nurse Manager #103.

A record review of the resident's progress notes from July 17, 2018- January 20, 2019 failed to identify any concerns raised by the resident.

A review of the 2018 complaint binder failed to identify any concerns brought forward by resident #011.

An interview with SW #118 confirmed that resident #011 had brought forward a concern about a PCA failing to assist them when they were struggling to assist their roommate but not the second issue related to the registered nurse. The SW shared that they passed along a message to Nurse Manager #103 that resident #011 was upset and asked them to speak with them.

An interview with Clinical Nurse Manager (CNM) #103 shared that the manager of the unit would investigate complaints and respond back to the complainant and document in the resident's progress notes. The CNM shared they did not recall hearing from SW #118 that resident #011 had reported their vitals and blood sugar levels had not been taken by an evening night nurse or that they had been ignored by a PCA when in need of assistance. The CNM shared that the SW did bring forward a concern that resident #011 was uncomfortable with a night male nurse and had followed up with the resident in this regard and communicated the concern to Nurse Manager Operational (NMO) #117.

An interview with Nurse Manager Operational #117 shared that whoever receives the resident complaint is responsible for following up with the resident. Inspectors #110 and #746 shared resident #011's concerns. The Nurse Manager stated it was the first time hearing of resident #011's concerns.. (110)

3. A complaint inspection, report #2019_486653_0004 related to complaints log #(s): 009354-17, 009967-17 was conducted concurrently by Inspector #653 which expanded the sample size to three residents/SDM.

The Ministry of Health and Long-Term Care (MOHLTC) ACTIONline had received complaint #IL-50769-TO on May 11, 2017, at 0938hrs, related to resident #009's bedtime, rest routines, and medication administration.

A review of resident #009's health records revealed they had been admitted to the home on April 28, 2017, and discharged from the home on August 7, 2017. The

resident was admitted to a private room with a shared washroom.

An interview with PSW #134 on February 4, 2019, at 0930hrs, indicated they recall resident #009's family complained about the co-neighbouring resident's screaming and yelling. A telephone interview with RN #133 on February 4, 2019, at 1100hrs, indicated resident #009's family member raised concerns on just about anything, and complained a lot.

An interview with Social Worker (SW) #131 on February 1, 2019, at 0850hrs, indicated they remember resident #009's family making numerous complaints and had issues around every discipline: food, rehab, and nursing. The SW stated that resident #009's family member constantly wrote e-mails to Previous Nurse Manager Operational (PNMO) #137. The SW further indicated the resident's family member had an issue around the co-neighbouring resident who shared the washroom with resident #009. The family member expressed concerns that the co-neighbouring resident was loud and disturbed resident #009's sleep.

A telephone interview with PNMO #137 on February 4, 2019, at 1337hrs, indicated they recall receiving concerns from resident #009's family member. The PNMO stated they would have documented on the concerns and complaints forms and placed it in a black binder kept in their previous office in the home.

A review of resident #009's family member's e-mail correspondence with the home revealed the following:
-On May 27, 2017, at 1740hrs, resident #009's family member had sent a four page e-mail addressed to the home's previous Administrator carbon copied to PNMO #137, the Assistant Administrator, and the DON. The e-mail had outlined concerns pertaining to resident #009's medication administration.
-On July 31, 2017, at 0120hrs, resident #009's family member had sent an e-mail addressed to PNMO #137, outlining concerns they had identified during their visit to the resident in the home on July 30, 2017. The e-mail indicated concerns in regards to resident #009 being congested and was choking later that day. The registered staff tried to suction the thick secretions from the resident's mouth, however, the suction machine was not working. The family member mentioned the prescribed Scopolamine drug had not been ordered from pharmacy, and also indicated concerns pertaining to turning and repositioning of resident #009 when in bed.
-On August 1, 2017, at 0106hrs, resident #009's family member had sent an e-mail

addressed to PNMO #137, outlining concerns they had identified during their visit to the resident in the home on July 31, 2017. The e-mail indicated concerns in regards to resident #009 not being turned and repositioned every two hours, catheter bag placed on the floor with a towel, and a registered staff's attitude towards the resident's family member.

During the course of the inspection, Inspector #653 reviewed the home's 2017 complaints binder and did not find any documented record of complaints pertaining to resident #009. NMO #117 also searched for PNMO #137's concerns and complaints black binder, however, they did not find it.

As per record reviews and staff interviews, the home was unable to provide evidence that a documented record was kept in the home that included (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, for the complaints they had received from resident #009's family member.

The severity of this issue was determined to be a level 1 as there was minimal harm or potential for actual harm to the resident.

The scope of the issue was a level 3 widespread as it related three out of three residents reviewed.

The home had a level 3 compliance history as there was one or more related non compliance within the last 3 years that included:
- written notification (WN) issued March 17, 2017 in report #2017_626501_0003 related to r. 101. (2) and r. 101. (1) 1 reporting and complaints.
-voluntary plan of correction (VPC) issued May 12, 2017 in report #2017_414110_0005 related to r. 101. (1) 1 reporting and complaints.

(110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 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 17th day of May, 2019 (A1)

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Amended by DIANE BROWN (110) - (A1)

Service Area Office / Bureau régional de services : Central East Service Area Office