Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 26, 2020	2020_805638_0014	017918-20, 017919-20, 017920-20, 017921-20	Follow up

Licensee/Titulaire de permis

Anson General Hospital
58 Anson Drive IROQUOIS FALLS ON P0K 1E0

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

South Centennial Manor
240 Fyfe Street IROQUOIS FALLS ON P0K 1E0

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

RYAN GOODMURPHY (638), STEVEN NACCARATO (744)

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): November 16 - 19, 2020.

The following intakes were completed as a result of this follow up inspection;
-One log which was a compliance order (#001) from inspection report #2020_771609_0015, regarding section 19 (1) of the Long-Term Care Homes Act (LTCHA) 2007, and the home's duty to protect residents from abuse and neglect;
-One log which was a compliance order (#002) from inspection report #2020_771609_0015, regarding section 24 (1) of the LTCHA 2007, and the home's requirement to immediately report certain matters to the Director;
-One log which was a compliance order (#003) from inspection report #2020_771609_0015, regarding section 9 (1) of the Ontario Regulation (O. Reg.) 79/10, and the security of doors in the home leading to non-residential areas; and,
-One log which was a compliance order (#004) from inspection report #2020_771609_0015, regarding section 17 (1) of the O. Reg. 79/10, and the home's communication and response system.

Please note: A critical incident system inspection (#2020_805638_0015) was conducted concurrently with this follow up inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Support Services Manager, Dietary Manager, Maintenance On-Site, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), housekeeping staff, residents and their families.

The Inspector(s) also conducted daily tours of resident care areas, reviewed relevant training records, tracking tools, policies and procedures, work orders, observed staff to resident interactions, provision of care and relevant resident health care records.

The following Inspection Protocols were used during this inspection:
Falls Prevention
Reporting and Complaints
Safe and Secure Home

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

- **3 WN(s)**
- **1 VPC(s)**
- **2 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. 19. (1)	CO #001	2020_771609_0015	744
LTCHA, 2007 S.O. 2007, c.8 s. 24. (1)	CO #002	2020_771609_0015	744
O.Reg 79/10 s. 9. (1)	CO #003	2020_771609_0015	638

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 LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Findings/Faits saillants :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every license that the licensee shall comply with every order made under this Act.

On September 1, 2020, compliance order (CO) #001 from inspection report #2020_771609_0015 was made under section 19 subsection 1 of the Long-Term Care Homes Act (LTCHA) 2007. The order indicated:

"The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.
Specifically, the licensee must:
a) Provide retraining and maintain records of the retraining to all staff on the definitions of abuse and neglect as defined by the Regulation;
b) Provide retraining and maintain records of the retraining to all staff on the responsibility of all staff related to the prevention, recognition, response, and reporting of abuse and neglect;
c) Ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident is immediately notified upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being;
d) Ensure that if staff members fail to adhere to the home's "Zero Tolerance of Abuse and Neglect" and/or "Duty to Report" policies, the home promptly acts to provide retraining, discipline and/or coaching, and that a record is maintained of the actions taken;
e) Develop a process by which staff who are known to have abused and/or neglected residents and continues to work with residents in the home are monitored and their on-going performance evaluated for three months or longer if continued concerns arise from their performance;
f) Ensure every alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated and that a record of the investigation is maintained."

The compliance due date was October 15, 2020.

The licensee completed steps c, d and f in CO #001; However, the licensee failed to

complete steps a, b and e prior to the compliance due date, regarding the required re-training of all staff and the development of a staff monitoring process. The DOC confirmed that steps a, b and e were completed; However, the compliance due date was not met.

Sources: Zero Tolerance of Abuse and Neglect Policy (last revised September 16, 2020); Return to work post CIS resident abuse and neglect investigation document, “Surge” course completion records; and interviews with the DOC and other staff. [s. 101. (3)]

2. On September 1, 2020, CO #002 from inspection report #2020_771609_0015 was made under section 24 of the LTCHA, 2007. The order indicated:

"The licensee must be compliant with s. 24 (1) LTCHA, 2007.
Specifically, the licensee must:
a) Ensure a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident’s money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006;
b) Provide retraining and maintain records of the retraining to the home’s Management/Leadership Team on their requirement under s. 24 (1) of the LTCHA, 2007 to immediately report all suspicions of abuse or neglect of residents;
c) Provide retraining and maintain records of the retraining to the home’s Management/Leadership Team on their requirement to submit Critical Incident reports with all the required information within the time frames set out under s. 107 of O. Reg. 79/10; and
d) Ensure that when the home receives a written complaint concerning the care of a resident or the operation of the long-term care home immediately forwards it to the Director."

The compliance due date was October 15, 2020.

The licensee completed steps a and d in CO #002; However, the licensee failed to complete steps b and c prior to the compliance due date, regarding the required

retraining for all the Management/Leadership Team as outlined. The DOC confirmed that steps b and c had been completed; However, the compliance due date was not met.

Sources: Zero Tolerance of Abuse and Neglect Policy (last revised September 16, 2020); "Surge" course completion records; and interviews with the DOC and other staff. [s. 101. (3)]

3. On September 1, 2020, CO #003 from inspection report #2020_771609_0015 was made under section 9 subsection 1 of the Ontario Regulation 79/10. The order indicated:

"The licensee must be compliant with r. 9. (1) 2 of O. Reg. 79/10.
Specifically, the licensee must:
a) Ensure all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff;
b) Ensure that keypad door codes to non-residential areas in the home are never posted where residents can access them;
c) Provide retraining and maintain records of the retraining to all staff on their responsibility to recognize and report broken or malfunctioning doors to the maintenance staff for prompt repair;
d) Develop an ongoing facility wide auditing process to ensure all doors to nonresidential areas are in proper working condition. Maintain a record of the ongoing process and the actions taken as a result of the process; and
e) Ensure that no supplies or equipment in the home obstruct or prevent doors to non-residential areas from closing."

The compliance due date was October 15, 2020.

The licensee completed steps a, b, d and e in CO #003; However, the licensee failed to complete step c regarding retraining and record retention of all staff on their responsibilities to recognize and report broken or malfunctioning doors. The Inspector reviewed the training records regarding section c of CO #003 and noted that 16 staff members had not signed the training record.

In an interview with the Dietary manager, they indicated that the outstanding staff members in their department did not complete their training as per the order, as they were already aware of the process. The Support Services manager indicated that all of their staff were re-oriented to the process on how to submit a request, but they did not

have them sign or maintain a record of completing the required training.

Sources: South Centennial Manor 2020 Hippo Training record; interviews with the Dietary manager, Support Services manager and other staff. [s. 101. (3)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

On September 1, 2020, compliance order #004 from inspection report #2020_771609_0015 was made under section 17 subsection 1 of the O. Reg. 79/10. The order indicated:

“The licensee must be compliant with r. 17. (1) (e) and r. 17. (1) (f) of O. Reg. 79/10. Specifically, the licensee must:
a) Ensure that the resident-staff communication and response system is available in every area accessible by residents and clearly indicates when activated where the signal is coming from;
b) Ensure that the home has an operable resident-staff communication and response system that complies with r. 17 of O. Reg. 79/10; and
c) Develop a temporary process by which staff are able to identify where signals are coming from until an operable resident-staff communication and response system is installed or repaired.”

The compliance due date was October 15, 2020.

Although the home had completed requirement “c” within the compliance order, the home remains non-compliant regarding having a communication and response system available in the previously identified resident accessible areas from inspection report #2020_771609_0015.

Inspector #638 conducted a tour of the home and was unable to locate a communication and response system in the areas, outlined in finding “1.” of compliance order #004 of inspection report #2020_771609_0015. Maintenance On-Site indicated, they had installed a new communication and response system, which was completed after the compliance due date, but they were still waiting for additional parts to install the communication response system in areas which were accessible to residents. The Maintenance On-site indicated there was nothing in place in the interim that could be considered a communication and response system in these areas.

Sources: Non-Stock Purchase Requisition; Inspector observations on November 15, 2020; interviews with Maintenance On-Site and other staff. [s. 17. (1) (e)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee has failed to ensure that hazardous substances were kept inaccessible to residents at all times.

Inspector #638 noted two aerosol cans which identified that their contents were flammable, under pressure and poisonous. The cans were located in an area which had no doors to keep these products inaccessible to residents. Maintenance On-Site indicated that these substances were to be stored in a locked cabinet and kept inaccessible to residents.

Sources: Inspector observations November 17, 2020; interviews with Maintenance On-Site and other staff. [s. 91.]

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 hazardous substances, including aerosol cans containing poisonous and flammable contents, are kept inaccessible to residents at all times, to be implemented voluntarily.

Issued on this 30th day of November, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère 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 Operations Division
Long-Term Care Inspections Branch

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	RYAN GOODMURPHY (638), STEVEN NACCARATO (744)
Inspection No. / No de l’inspection :	2020_805638_0014
Log No. / No de registre :	017918-20, 017919-20, 017920-20, 017921-20
Type of Inspection / Genre d’inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Nov 26, 2020
Licensee / Titulaire de permis :	Anson General Hospital 58 Anson Drive, IROQUOIS FALLS, ON, P0K-1E0
LTC Home / Foyer de SLD :	South Centennial Manor 240 Fyfe Street, IROQUOIS FALLS, ON, P0K-1E0
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Paul Chatelain

To Anson General Hospital, you are hereby required to comply with the following order (s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, Conditions of licence
s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Connecting Care Act, 2019, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts.

Order / Ordre :

The licensee must be compliant with section 101. (3) of the Long-Term Care Home's Act, 2007.

Specifically, the licensee must;

a) Develop a system to track and maintain a record of the progression of each requirement made in a compliance order issued under the Act; and,

b) Appoint a lead responsible for tracking and ensuring the completion of all order requirements made under the Act.

Grounds / Motifs :

1. The licensee has failed to comply with the following requirement of the LTCHA: it is a condition of every license that the licensee shall comply with every order made under this Act.

On September 1, 2020, compliance order (CO) #001 from inspection report #2020_771609_0015 was made under section 19 subsection 1 of the Long-Term Care Homes Act (LTCHA) 2007. The order indicated:

"The licensee must be compliant with s. 19 (1) of the Long-Term Care Homes Act (LTCHA), 2007.
Specifically, the licensee must:
a) Provide retraining and maintain records of the retraining to all staff on the definitions of abuse and neglect as defined by the Regulation;

b) Provide retraining and maintain records of the retraining to all staff on the responsibility of all staff related to the prevention, recognition, response, and reporting of abuse and neglect;
c) Ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident is immediately notified upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being;
d) Ensure that if staff members fail to adhere to the home's "Zero Tolerance of Abuse and Neglect" and/or "Duty to Report" policies, the home promptly acts to provide retraining, discipline and/or coaching, and that a record is maintained of the actions taken;
e) Develop a process by which staff who are known to have abused and/or neglected residents and continues to work with residents in the home are monitored and their on-going performance evaluated for three months or longer if continued concerns arise from their performance;
f) Ensure every alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee knows of, or that is reported to the licensee, is immediately investigated and that a record of the investigation is maintained."

The compliance due date was October 15, 2020.

The licensee completed steps c, d and f in CO #001; However, the licensee failed to complete steps a, b and e prior to the compliance due date, regarding the required re-training of all staff and the development of a staff monitoring process. The DOC confirmed that steps a, b and e were completed; However, the compliance due date was not met.

Sources: Zero Tolerance of Abuse and Neglect Policy (last revised September 16, 2020); Return to work post CIS resident abuse and neglect investigation document, "Surge" course completion records; and interviews with the DOC and other staff. [s. 101. (3)]

2. On September 1, 2020, CO #002 from inspection report #2020_771609_0015 was made under section 24 of the LTCHA, 2007. The order indicated:

"The licensee must be compliant with s. 24 (1) LTCHA, 2007.
Specifically, the licensee must:
a) Ensure a person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006;
b) Provide retraining and maintain records of the retraining to the home's Management/Leadership Team on their requirement under s. 24 (1) of the LTCHA, 2007 to immediately report all suspicions of abuse or neglect of residents;
c) Provide retraining and maintain records of the retraining to the home's Management/Leadership Team on their requirement to submit Critical Incident reports with all the required information within the time frames set out under s. 107 of O. Reg. 79/10; and
d) Ensure that when the home receives a written complaint concerning the care of a resident or the operation of the long-term care home immediately forwards it to the Director."

The compliance due date was October 15, 2020.

The licensee completed steps a and d in CO #002; However, the licensee failed to complete steps b and c prior to the compliance due date, regarding the required retraining for all the Management/Leadership Team as outlined. The DOC confirmed that steps b and c had been completed; However, the compliance due date was not met.

Sources: Zero Tolerance of Abuse and Neglect Policy (last revised September 16, 2020); "Surge" course completion records; and interviews with the DOC and other staff. [s. 101. (3)]

3. On September 1, 2020, CO #003 from inspection report #2020_771609_0015

was made under section 9 subsection 1 of the Ontario Regulation 79/10. The order indicated:

"The licensee must be compliant with r. 9. (1) 2 of O. Reg. 79/10.
Specifically, the licensee must:
a) Ensure all doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff;
b) Ensure that keypad door codes to non-residential areas in the home are never posted where residents can access them;
c) Provide retraining and maintain records of the retraining to all staff on their responsibility to recognize and report broken or malfunctioning doors to the maintenance staff for prompt repair;
d) Develop an ongoing facility wide auditing process to ensure all doors to nonresidential areas are in proper working condition. Maintain a record of the ongoing process and the actions taken as a result of the process; and
e) Ensure that no supplies or equipment in the home obstruct or prevent doors to non-residential areas from closing."

The compliance due date was October 15, 2020.

The licensee completed steps a, b, d and e in CO #003; However, the licensee failed to complete step c regarding retraining and record retention of all staff on their responsibilities to recognize and report broken or malfunctioning doors. The Inspector reviewed the training records regarding section c of CO #003 and noted that 16 staff members had not signed the training record.

In an interview with the Dietary manager, they indicated that the outstanding staff members in their department did not complete their training as per the order, as they were already aware of the process. The Support Services manager indicated that all of their staff were re-oriented to the process on how to submit a request, but they did not have them sign or maintain a record of completing the required training.

Sources: South Centennial Manor 2020 Hippo Training record; interviews with the Dietary manager, Support Services manager and other staff.

The decision to issue a compliance was based on the severity of the issue, which was a level one, indicating that there was minimal risk to residents. The scope of the issue was a level three, indicating that the issue was widespread. The home had a level three compliance history, with related non-compliance in the last 36 months under this section of the LTCHA, which included;
- A voluntary plan of correction issued October 2019, during inspection #2019_680687_0026. (744)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 26, 2021

Ontario

Ministry of Long-Term Care

Ministère 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

Order # / No d'ordre : 002

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

Linked to Existing Order / Lien vers ordre existant: 2020_771609_0015, CO #004;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Order / Ordre :

The licensee must be compliant with s. 17 (1) of the Ontario Regulation 79/10.

The licensee shall prepare, submit and implement a plan to ensure that the home is equipped with a resident-staff communication and response system that is available in every area accessible by residents.

The plan must include, but is not limited to, the following:

a) What the home plans to implement as a staff-resident communication and response system in the outstanding resident accessible areas, including how it will be integrated into the existing system; and,

b) How the areas that are resident accessible and do not currently have a staff-resident communication and response system will be monitored in the interim to ensure resident safety.

Please submit the written plan, quoting inspection #2020_805638_0014 and Inspector Ryan Goodmurphy, by email by December 11, 2020.

Please ensure that the submitted written plan does not contain any personal information or personal health information.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident-staff communication and response system was available in every area accessible by residents.

On September 1, 2020, compliance order #004 from inspection report #2020_771609_0015 was made under section 17 subsection 1 of the O. Reg. 79/10. The order indicated:

"The licensee must be compliant with r. 17. (1) (e) and r. 17. (1) (f) of O. Reg. 79/10.
Specifically, the licensee must:
a) Ensure that the resident-staff communication and response system is available in every area accessible by residents and clearly indicates when activated where the signal is coming from;
b) Ensure that the home has an operable resident-staff communication and

response system that complies with r. 17 of O. Reg. 79/10; and
c) Develop a temporary process by which staff are able to identify where signals are coming from until an operable resident-staff communication and response system is installed or repaired."

The compliance due date was October 15, 2020.

Although the home had completed requirement "c" within the compliance order, the home remains non-compliant regarding having a communication and response system available in the previously identified resident accessible areas from inspection report #2020_771609_0015.

Inspector #638 conducted a tour of the home and was unable to locate a communication and response system in the areas, outlined in finding "1." of compliance order #004 of inspection report #2020_771609_0015. Maintenance On-Site indicated, they had installed a new communication and response system, which was completed after the compliance due date, but they were still waiting for additional parts to install the communication response system in areas which were accessible to residents. The Maintenance On-site indicated there was nothing in place in the interim that could be considered a communication and response system in these areas.

Sources: Non-Stock Purchase Requisition; Inspector observations on November 15, 2020; interviews with Maintenance On-Site and other staff.

The decision to issue a compliance order was based on the severity of the issue, which was a level two, indicating that there was a risk of harm to residents. The scope of the issue was a level three, indicating that the issue was widespread. The home's compliance history for the issue was a level four, with related non-compliance in the last 36 months under this section of the O. Reg 79/10, which included;
-A compliance order issued September 1, 2020, from inspection report #2020_771609_0015. (638)

Ontario

Ministry of Long-Term Care

Ministère 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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 26, 2021

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 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 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 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 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 26th day of November, 2020

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Ryan Goodmurphy

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