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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Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Oct 07, 2021	2021_621755_0021 (A1)	009566-21, 009860-21, 010021-21, 011111-21, 011244-21, 011288-21, 011300-21, 011301-21, 011303-21, 011488-21, 011492-21, 011550-21, 012961-21, 013030-21, 013032-21	Complaint

Licensee/Titulaire de permis

Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
161 Bay Street Suite 2100 Toronto ON M5J 2S1

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

Perth Community Care Centre
101 Christie Lake Road, R. R. #4 Perth ON K7H 3C6

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

Amended by MANON NIGHBOR (755) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

This public inspection report has been revised to reflect a change in the date to submit the plan for compliance orders s. 153. (1) (b)related to s. 8.1 Personal Worker and Nursing services organized programs for the home to meet the assessed needs of the residents. This Complaint Inspection #2021-621755-0021 was completed on August 25, 2021.
A copy of the revised report is attached.

Issued on this 7 th day of October, 2021 (A1)

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

Original report signed by the inspector.

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

Amended by MANON NIGHBOR (755) - (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): July 22, 23, 26-30, August 3-6, 9-13, 16-20, 23-25, 2021

The following intakes were competed in this complaint inspection:

Logs # 009566-21, 009860-21, 010021-21, 011111-21, 011244-21, 011288-21, 011300-21, 011301-21, 011303-21, 011488-21, 011492-21, 011550-21, 012961-21, 013030-21, 013032-21 were related to insufficient staffing, food services, nutrition, continence care, transfers, bathing, monitoring of residents, falls, infection prevention and control (IPAC), medication management system quarterly assessments, staff towards resident abuse, registered nurse availability, interdisciplinary communication, plan of care quarterly assessments, social worker role, head injury routine assessments, activities, responsive behaviours, administration and management.

During the course of the inspection, the inspector(s) spoke with Acting Administrator and Vice President of Operations and Vice President of Senior Living Operations, Interim Administrator, Director of Care, Acting Director of Care and Clinical Director, Clinical Manager, Resident Assessment Instrument Minimum Data Set Coordinator, Office Manager, Physicians, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Resident Care Attendants (RCAs), Physiotherapist (PT), Physiotherapy Assistant (PTA), Scheduler, Food Service Manager, Registered Dietitian (RD), Social Workers (SW), Recreational Coordinator, Recreational Aid, Maintenance and Housekeeping personnel, Environmental Coordinator, screener, agency staff, residents and resident's family members.

During the course of the inspection, the inspector reviewed relevant, resident's health care records, policies and procedures, professional committees documents, staffing schedules, air temperature records, observed the provision of care and resident's environment.

Please note that the inspection report #2021_621755_0023 was conducted concurrently with this inspection and non-compliances related to LTCHA 2007, s. 6 (1) and (a) and s. 6 (9) related to complaint logs #010209-21, #010633-21 and #010987-21 are referred in this inspection.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

During the course of the original inspection, Non-Compliances were issued.
12 WN(s)
10 VPC(s)
3 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. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the Skin Care Program: Assessment and Care Planning Policy included in the required Skin and Wound Care Program was

complied with for three residents.

O. Reg. 79/10 s. 48(1) requires the licensee to have a skin and wound care program developed and implemented within the home to maintain skin integrity and prevent wounds and O. Reg. 79/10 s.30(1) requires that this program include relevant policies, procedures and protocols to reduce risk and monitor outcomes.

Specifically, the licensee's Skin Care Program: Assessment and Care Planning Policy #NUR 03-01-41 was not complied with.

The policy described that each resident who exhibits skin breakdown and/or pressure and skin injuries must be assessed each week by a member of the registered nursing staff using the Weekly Wound Assessment Tool in Point Click Care (PCC), and that assessments are to be documented. It also described that the skin care routine will be fully documented in the care plan. The care plan will be reviewed quarterly, and as the condition changes. It further described that a resident care plan should reflect the level of risk for skin integrity impairment, interventions related to skin integrity and wound care, and evaluation of strategies.

Two staff members described that weekly assessments of residents exhibiting altered skin integrity would be documented under a skin progress note.

Three resident's health record were reviewed and found that their weekly wound assessments were not being completed using the specified Weekly Wound Assessment Tool in PCC and the resident's plan of care did not describe the resident's wounds, skin care routine, or interventions and treatment related to skin integrity and wound care. Two out of the three residents also did not have a documented weekly wound assessment two times during that time period. A staff member said that one resident's wounds required cleansing a different times depending on their wound condition and that the resident received a Skin Assessment regularly, however this was not always documented. In a period of four months one resident had 17 missing assessments. A staff member confirmed that the Weekly Wound Assessment Tool in PCC should be used to document weekly wound assessments and that the care plan should include residents skin care routine as described in the policy.

Sources:

Reviewed resident's relevant health care records including progress notes, plan of care and skin assessments.
Policies Skin Care Program: Assessment and Care Planning Policy #NUR 03-01-41
Interviews with Acting DOC and three staff members.

The licensee has failed to ensure that the Resident Falls Policy included in the required Falls Prevention and Management Program was complied with for six residents.

O. Reg. 79/10 s. 48(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury and O. Reg. 79/10 s.30(1) requires that this program include relevant policies, procedures and protocols to reduce risk and monitor outcomes.

Specifically, the licensee's Resident Falls Policy #NUR 05-02-01 was not complied with.

Resident Falls Policy #NUR 05-02-01 specified that if a resident may have hit their head, a Head Injury Routine (HIR) must be initiated.

The acting DOC further explained to Inspector that the Head Injury Routine Form (05-04-02) described the frequency at which the HIR must be completed. It specified that, unless otherwise ordered by physician, HIR is to be completed every 15min four times, every 30min four times, every hour four times, then if stable every four hours until 72 hours after the suspected head injury has been reached.

A resident had an unwitnessed fall. A HIR was initiated and of the 28 HIR assessments required to be completed, only 12 were done. A staff member who worked the next day, recalled that they had missed completing some of the HIR assessments because there was no RN on the floor. They said that the RN is usually responsible for completing the HIR and the RPN gives out the medications. The schedule confirmed that there was no RN for the shift the staff member was referring to, on the resident's floor.

A registered staff member assessed a resident after their witnessed fall and found

a bump on their forehead and subsequently initiated a HIR. The second assessment was due fifteen minutes later was completed five hours later. This was the last entry before the resident was found medically unstable nine hours later and sent to hospital. A staff member said that it was the RN's role to complete the HIR because the RPN's role was to pass medication. A staff member on duty that shift, said they did the first assessment and the next one before they left but were unable to complete the other assessments due to competing priorities and they were short staff.

Resident Falls Policy #NUR 05-02-01, Procedure #3. states that a huddle is to take place immediately post fall to identify the root reason for resident falling and #14a. indicated that all sections of the electronic post fall Risk Management in Point Click Care (PCC) must be completed including the documentation of the huddle in the Action tab. Three different staff members confirmed that the related sections for the huddle, Morse Fall Scale, skin and pain assessments were not completed for this resident's fall.

Another resident had a fall with 4 out of the 28 HIR assessments that were not completed. After 56 hours, a staff member completed the assessments. The same resident had a another fall where a HIR was initiated and 9 assessments were not documented, with 19 hours between two of the documented assessments. Sixteen days later, the same resident fell and a HIR was initiated and 12 assessments were not documented.

Another resident fell and the 15 minutes HIR assessments were not completed and ten documented assessments were missing on the HIR form. A staff member said that the HIR assessments were not passed on from shift to shift. They reported that on an evening shift, they came at 1500 hours and there were no assessments recorded since 0700 hours.

Another resident fell and a HIR was initiated. There were a total of five HIR documented assessments missing up to when resident fell again 48 hours post initial fall.

Another resident fell. A HIR was initiated and the next entry was 20 hours later.

Another resident fell. A HIR was initiated and nine HIR assessments were not documented out of 28.

Sources:
Reviewed relevant residents health care records including progress notes. HIR forms for six residents. Staff schedule.
Policies and forms: Resident Falls Policy #NUR 05-02-01
Interviews with six staff members and other staff.

Additional Required Actions:

CO # - 001, 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

The licensee failed to ensure the organized program of personal support and nursing services met the assessed needs of the residents.

The home has had a decrease in their human resources, specifically their PSWs and registered staff. Multiple findings of non-compliance identified throughout the inspection made reference to the the lack of personal support and nursing services available to meet the assessed resident needs.

In reference to WN #2, staff members involved explained that for six residents the Head Injury Routine (HIR) assessments were incomplete because they were short registered staff.

In reference to WN #4, wound care was not provided to a resident as indicated by a staff member who described that they were short staffed and did not have a second staff member to assist them. Four residents did not have clear directions of their assessed needs. Staff members said that there was a lack and inconsistency of registered nurses, which up to recently were responsible for updating the resident’s plan of care. Another staff member attributed a wound not cleansed due to lack of time as there was no RN on the floor, as confirmed by review of the schedule.

In reference to WN #8, both staff members expressed that baths did not occur due to short staffing. Review of the schedule confirmed that one of those days when a resident did not receive their bath, the unit was short one PSW member.

In reference to WN #12, staff members confirmed that IPAC meetings were not held quarterly as they did not have sufficient staff to allow participation in the meetings.

Sources:
Reviewed relevant health care records including progress notes, plan of care, POC, bathing documentation, skin care assessments, HIR forms, Professional Practice Committee, PAC and IPAC related documents, Staff schedules.
Policies #NUR 05-02-01 and #NUR 03-01-41.
Interviews with fifteen staff members.

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the “Order(s) of the Inspector”.

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003

WN #3: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

The licensee has failed to ensure that the plan of care set out clear direction for staff for the personal care routine of three residents.

1. The plan of care for a resident stated that they were incontinent and were not provided with assistance with toileting. The plan of care indicated the size of brief the resident required, however it did not indicate when the resident should have received personal care. A staff member stated that the resident was provided care prior to breakfast and helped to bed after the meal. The resident was then provided care again prior to lunch and was not provided personal care again until the evening shift. A different staff member stated that the resident was provided care prior to dinner, after dinner when they were helped to bed, and often provided care again before the end of the evening shift.

2. A resident's plan of care indicated they were incontinent and were not provided assistance with toileting. The plan of care did not mention what size of incontinence brief or when the resident should of receive personal care. A staff member stated that the resident was provided personal care prior to breakfast and then helped to bed after the meal. The resident was then provided care again just prior to lunch and did not receive care again in the afternoon. A different staff member stated that the resident was provided personal care before and after dinner.

3. Another resident's plan of care outlined that the resident did not require the use of the toilet and used an incontinence brief. The plan of care did not mention what size of incontinence brief is required or when the resident was to receive personal care. A staff member stated that the resident was provided personal care between breakfast and lunch. The resident then wasn't provided care until the evening shift. Another staff member stated that the resident received personal care prior to dinner if they had a bowel movement and they were helped to bed after dinner.

Two staff members confirmed that there was not a written plan of care that sets out clear direction related to the planned personal care routine for three residents and this was only available by word of mouth.

Sources:
Reviewed three resident's relevant health care records including plan of care and Point of Care documentation.
Interviews with three staff members.

4. The licensee failed to ensure that the plan of care set out clear direction in regard to the use of a 4-wheel walker for a resident.

A resident experienced falls, following a decline in functional status. The resident was reassessed, and a 4-wheel walker was suggested for use during ambulation. The resident experienced two more falls following reassessment, in which the resident sustained an injury and passed away days later.

A staff member stated they updated the plan of care to reflect the resident’s most current gait and mobility requirements. However, the resident’s plan of care did not indicate the use of a 4-wheel walker for ambulation.

Sources:
Reviewed resident’s relevant healthcare record including progress notes, care plan, and referrals.
Interview with a staff member and others.

5. The licensee has failed to ensure that the plan of care set out clear direction in regard to a resident's recreation interventions.

The resident's written electronic plan of care in Point Click Care (PCC) stated that the recreation team was to provide the resident with a one to one session at certain intervals. The activation notes were reviewed for a three month period and the documentation did not reflect this was being done at the specified intervals. Two staff members confirmed that the recreation team provided the resident with one to one sessions at different intervals which was not reflected in their written plan of care.

Sources:
Resident’s relevant healthcare record including progress notes, care plan, and activation note.
Interviews with two staff members.

6. The licensee has failed to ensure that a resident’s wounds were cleansed as per their plan of care.

The resident had areas of skin breakdown. The resident’s wounds required cleansing at different times depending on the wound's condition. This was to be done on an as needed basis when requested by the resident.

A staff member told Inspector that the resident requested their wounds cleansed

on an evening shift, however, they were unable to cleanse it and provide care due to lack of time as there was no RN on the floor. Review of staff schedule confirmed a the lack of RN at that time.

Sources:
Reviewed of resident's relevant health care record; intake log #009566-21 and staff schedule.
Interviews with three staff members.

7. The licensee has failed to ensure that the care set out in the plan of care related to perineal care was provided to a resident.

The resident's plan of care set out direction that they be provided with perineal care twice per shift. The Point of Care (POC) documentation had marked that the perineal care required twice per shift was not provided and the personal care section was marked as not applicable.

A staff member stated that this documentation showed that the care was not provided to the resident. They stated they were short staff on this shift and did not have a second staff member to assist with the resident's care.

Sources:
Reviewed resident's healthcare record including care plan and Point of Care documentation (POC).
Interviews with a staff member and others.

8. The licensee has failed to ensure that the provision of care set out in the plan of care was documented for three residents.

A day in August, three resident's POC documentation required each shift were left blank in the personal hygiene and oral care areas. In addition two of the residents areas not documented included continence care, dressing and transferring and one of the resident's area of care also not documented was their behaviour monitoring.

A staff member stated they did not have enough time to complete the POC documentation for the residents however the care was completed.

Sources:

Reviewed three resident’s healthcare record including care plan and POC.
Interviews with a staff member and others.

9. The licensee has failed to ensure that the provision of care set out in the plan of care was documented for a resident.

A registered staff administered a medication for resident's comfort and did not record it in the PCC Electronic Medication Administration Record (EMAR). The staff member shared that they had forgotten to record the administration of the medication in the EMAR.

The resident's plan of care stated that their continence and toileting care was to be recorded every shift in POC. There was no documentation in resident's toileting, bladder continence and bowel continence sections. The staff member said they must have forgotten to document the care delivered to the resident that day. They said they were too busy and were prioritizing the resident's care over documentation.

Sources:
Reviewed resident’s healthcare record including care plan, POC and EMAR.
Interviews with two staff members.

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 there is a written plan of care for each resident that sets out, the planned care for the resident; clear directions to staff and others who provide direct care to the resident that the care set out in the plan of care is provided to the resident as specified in the plan and the provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Findings/Faits saillants :

The licensee failed to ensure that the home was maintained of a minimum temperature of 22 degrees Celsius.

The air temperature monitoring record in place showed air temperatures in lounge areas of the home below 22 degrees Celsius on July 23-25, 27-31, and August 1-5, 2021. A staff member confirmed that the air temperatures on the days listed were below the minimum requirement.

Sources:
Ambient Room Temperature logs.
Interviews with a staff member and others.

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 the home is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) 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. 2007, c. 8, s. 24 (1), 195 (2).
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. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident occurred, immediately report the suspicion and the information upon which it was based to the Director.

A staff member described to an Inspector an incident that occurred where they witnessed another staff member use excessive force on a resident and felt it was abuse. They indicated that they reported this to the registered staff at the time and told the other staff member about it, but not on the day it occurred. The staff member also completed a written statement in the form of a Report of Concern nine days later, that described the incident and submitted this to a staff member that same day. The staff member acknowledged that this was not immediately

reported.

Another staff member described that they recalled hearing about the incident but that it was not looked into by them. They stated that an investigation was not started for this incident and that a Critical Incident Report (CIR) was not filled out.

Inspector was unable to find a report to the Director regarding the alleged staff to resident abuse of the resident, despite three staff members being aware of it.

Sources:
Reviewed the resident’s relevant health care record; Report of Concern letter and review of LTCH.net and CSC server.
Interview with two staff members and other staff.

2. The licensee has failed to ensure that any person who had reasonable grounds to suspect that a resident received improper care immediately reported the suspicion and the information to the Director.

A staff member reported that they were notified that the resident had not received personal care for approximately 20 hours. When interviewed, the staff member stated they suspected the resident had not received personal care based on their observations of the resident and their condition.

A staff member reported they were not immediately notified of this allegation but confirmed that a report to the Director would be required, as well as an investigation into the allegation.

Sources:
Reviewed the resident's healthcare record
Policy #RC 01-01-12 Zero Tolerance to Resident Abuse and Neglect, last revised on August 6, 2021.
Interviews with three staff members and others.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a person who has reasonable grounds to suspect that improper or incompetent treatment or care or abuse of a resident by anyone that resulted in harm or a risk of harm to the resident has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

The licensee has failed to ensure that a Registered Dietitian who is a member of the staff of the home completed a nutritional assessment for all residents on admission including the assessment of nutritional status including height, weight and any risks relating to nutritional care as well as hydration status and any risks related to hydration.

The Registered Dietitian completed admission nutritional assessments as a progress note in the residents electronic chart as evidenced by a health record review of six newly admitted residents to the home. Two of these residents did not have an admission nutrition assessment completed as per review of their electronic health record in August, 2021.

There was no onsite dietitian between July 8 and August 14, 2021.

Sources:
Reviewed six residents relevant health including plan of care.
Interview with a staff member.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a registered dietitian who is a member of the staff of the home, completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

s. 33. (1) Every licensee of a long-term care home shall ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition. O. Reg. 79/10, s. 33 (1).

Findings/Faits saillants :

The licensee has failed to ensure that two residents were bathed, at a minimum, twice a week.

Two residents were to be bathed on 2 different days of the week. A staff member confirmed that neither resident received their second bath scheduled for a week in June, 2021. Another staff member confirmed that one of the residents also did not receive their first scheduled bath of a week in June, 2021.

Both staff members expressed that the baths did not occur due to short staffing. Review of the schedule confirmed that on that date in June, 2021 the unit was short one PSW staff member. Staff documentation revealed that the baths were not made up for on other days.

Sources:
Reviewed two resident's relevant health including including staff documentation for bathing on two days in June, 2021.
Interview with two staff members and other staff.

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 each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a Registered Dietitian (RD) was on site for a minimum 30 minutes per resident per month to carry out clinical and nutrition care duties for the month of July, 2021.

The previous RD's last day working in the home was July 8, 2021. They worked a total of 22.5 hours out of the required 60 hours for the month of July. There was no onsite RD between July 8 and August 14, 2021.

Sources:
Reviewed resident's relevant health care records including plan of care and previous RD's invoiced hours for July 2021.
Interviews with a staff member and Universal Care– Vice President of Operations and Building Services.

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 there is at least one registered dietitian for the home who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 115. Quarterly evaluation

Specifically failed to comply with the following:

s. 115. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 115 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the interdisciplinary team met at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The licensee’s Medication Errors policy outlined that medication incident reports would be reviewed at the Professional Advisory Committee (PAC) and areas where improvements in practice are required would be identified. The meeting minutes of this committee showed they met on December 19, 2019, September 29, 2020, and November 5, 2020.

A staff member confirmed that a PAC meeting had not been held since November 2020. They stated the meeting was postponed multiple times before it was cancelled.

The failure to ensure that the PAC met at least quarterly to evaluate the effectiveness of the medication management system presented a risk to residents related to the lack of evaluation of medication incident trends and the improvements that could be made to prevent these in the future.

Sources:
Professional Advisory Committee meeting notes.
Policy #RC 04-01-12 Medication Errors, last revised on June 1, 2020.
Interviews with two staff members and others.

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 an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, meets at least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 126. Every licensee of a long-term care home shall ensure that drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed. O. Reg. 79/10, s. 126.

Findings/Faits saillants :

The licensee failed to ensure that drugs for three residents remained in the original labeled container or package provided by the pharmacy service provider or the Government of Ontario until administered.

An observation was completed, after a staff member brought forward concern about the medication carts. Three residents had medication in their respective boxes that had been removed from the original packaging and placed in a medication cup. The staff member identified one of the resident’s medication was a controlled substance.

Another staff member acknowledged that some medication, including controlled substances, were not remaining in the original packaging until administration.

The failure to ensure medication remained in the original package presented a risk to residents as the absence of the original label could contribute to medication errors.

Sources:
Observation of medication carts.
Reviewed three resident's relevant healthcare records.
Policy #RC 04-01-12 Medication Errors, last revised on June 1, 2020.
Interviews with two staff members and others.

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 drugs remain in the original labelled container or package provided by the pharmacy service provider or the Government of Ontario until administered to a resident or destroyed, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

The licensee has failed to ensure that controlled substances were stored in a separate locked area within the locked medication cart.

Observations of the medication carts were completed. The medication carts were observed to be locked, however the separate area for controlled substances was not locked.

A staff member stated they were aware that controlled substances were not always being double locked in the medication carts and they would be looking into the scope of this issue.

Sources:
Observations of medication carts.
Policy #RC 04-01-12 Medication Errors, last revised on June 1, 2020.
Interviews with a staff member and others.

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 controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (2) The licensee shall ensure,
(b) that the interdisciplinary team that co-ordinates and implements the program meets at least quarterly; O. Reg. 79/10, s. 229 (2).

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

The licensee has failed to ensure that the Infection Prevention and Control (IPAC) interdisciplinary team met at least quarterly.

A staff member reported that the IPAC interdisciplinary team meetings were incorporated into the Professional Practice meetings. The Professional Practice committee met and discussed the implementation of the IPAC program on July 30, 2020, November 24, 2020, and December 17, 2020. The Professional Practice committee met again on June 2, 2021, however IPAC co-ordination and implementation were not discussed.

Two other staff members confirmed that IPAC meetings were not held quarterly and that there were no further committee meetings regarding the coordination and implementation of the IPAC program.

Sources:
Professional Practice Committee minutes.
Policy: Infection Prevention and Control Program #: INF 01-03, last revised December 1, 2019.
Interviews with three staff members and others.

The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

A resident's room was observed to have a personal protective equipment (PPE) storage unit on the door but did not have additional precaution signage. Furthermore, a visitor was observed to be seated beside a resident of this room and the visitor was only wearing a procedure mask. A staff member confirmed the room required additional precautions and should have had signage to indicate this. In addition, the staff member confirmed that the visitor would have required additional personal protective equipment to be seated beside a resident of this room.

Sources:
Observations of resident rooms.
Reviewed resident's relevant healthcare records including progress notes.
Interviews with a staff member and others.

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 the interdisciplinary team that co-ordinates and implements the IPAC program meets at least quarterly and that all staff participate in the implementation of the program, to be implemented voluntarily.

Issued on this 7 th day of October, 2021 (A1)

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

Original report signed by the inspector.

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by MANON NIGHBOR (755) - (A1)

Inspection No. / No de l'inspection : 2021_621755_0021 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 009566-21, 009860-21, 010021-21, 011111-21, 011244-21, 011288-21, 011300-21, 011301-21, 011303-21, 011488-21, 011492-21, 011550-21, 012961-21, 013030-21, 013032-21 (A1)

Type of Inspection / Genre d'inspection : Complaint

Report Date(s) / Date(s) du Rapport : Oct 07, 2021(A1)

Licensee / Titulaire de permis : Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation
161 Bay Street, Suite 2100, Toronto, ON, M5J-2S1

LTC Home / Foyer de SLD : Perth Community Care Centre
101 Christie Lake Road, R. R. #4, Perth, ON, K7H-3C6

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Astrida Kalnins

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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

To Arch Long Term Care LP by its General Partner, Arch Long Term Care MGP, by its partners, Arch Long Term Care GP Inc. and Arch Capital Management Corporation, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / No d'ordre: 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 8 (1).

Specifically, the licensee shall develop and implement, education, monitoring, communication and remedial processes as follows:

A) Ensure that all registered staff, including frequently scheduled agency staff, communicate between shifts when a head injury routine has been initiated, that clear directions are in place related to who is responsible to complete the head injury routine assessments and that a back-up plan is in place for how the head injury routines assessments will be completed when there is a shortage of staff.

B) Ensure that registered staff are completing and documenting head injury routine assessments as per the licensee's fall prevention policy.

C) Perform bi-weekly audits on the frequency and completion of the head injury routine forms, until consistent compliance is achieved.

D) Take immediate corrective action if deviations occur from established Resident Falls policy.

E) A written record must kept of everything required under (a), (b), (c) and (d).

Grounds / Motifs :

1. The licensee has failed to ensure that the Resident Falls Policy included in the required Falls Prevention and Management Program was complied with for six residents.

O. Reg. 79/10 s. 48(1) requires the licensee to have a falls prevention and management program developed and implemented within the home to reduce the incidence of falls and the risk of injury and O. Reg. 79/10 s.30(1) requires that this program include relevant policies, procedures and protocols to reduce risk and monitor outcomes.

Specifically, the licensee's Resident Falls Policy #NUR 05-02-01 was not complied with.

Resident Falls Policy #NUR 05-02-01 specified that if a resident may have hit their head, a Head Injury Routine (HIR) must be initiated.

The acting DOC further explained to Inspector that the Head Injury Routine Form (05 -04-02) described the frequency at which the HIR must be completed. It specified that, unless otherwise ordered by physician, HIR is to be completed every 15min four times, every 30min four times, every hour four times, then if stable every four hours until 72 hours after the suspected head injury has been reached.

A resident had an unwitnessed fall. A HIR was initiated and of the 28 HIR assessments required to be completed, only 12 were done. A staff member who worked the next day, recalled that they had missed completing some of the HIR assessments because there was no RN on the floor. They said that the RN is usually responsible for completing the HIR and the RPN gives out the medications. The schedule confirmed that there was no RN for the shift the staff member was referring to, on the resident's floor.

A registered staff member assessed a resident after their witnessed fall and found a bump on their forehead and subsequently initiated a HIR. The second assessment was due fifteen minutes later was completed five hours later. This was the last entry before the resident was found medically unstable nine hours later and sent to hospital. A staff member said that it was the RN's role to complete the HIR because the RPN's role was to pass medication. A staff member on duty that shift, said they did the first assessment and the next one before they left but were unable to complete the other assessments due to competing priorities and they were short staff.

Resident Falls Policy #NUR 05-02-01, Procedure #3. states that a huddle is to take place immediately post fall to identify the root reason for resident falling and #14a. indicated that all sections of the electronic post fall Risk Management in Point Click Care (PCC) must be completed including the documentation of the huddle in the Action tab. Three different staff members confirmed that the related sections for the huddle, Morse Fall Scale, skin and pain assessments were not completed for this resident's fall.

Another resident had a fall with 4 out of the 28 HIR assessments that were not

completed. After 56 hours, a staff member completed the assessments. The same resident had a another fall where a HIR was initiated and 9 assessments were not documented, with 19 hours between two of the documented assessments. Sixteen days later, the same resident fell and a HIR was initiated and 12 assessments were not documented.

Another resident fell and the 15 minutes HIR assessments were not completed and ten documented assessments were missing on the HIR form. A staff member said that the HIR assessments were not passed on from shift to shift. They reported that on an evening shift, they came at 1500 hours and there were no assessments recorded since 0700 hours.

Another resident fell and a HIR was initiated. There were a total of five HIR documented assessments missing up to when resident fell again 48 hours post initial fall.

Another resident fell. A HIR was initiated and the next entry was 20 hours later.

Another resident fell. A HIR was initiated and nine HIR assessments were not documented out of 28.

Sources:
Reviewed relevant residents health care records including progress notes. HIR forms for six residents. Staff schedule.
Policies and forms: Resident Falls Policy #NUR 05-02-01
Interviews with six staff members and other staff.

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to the six residents who's head injury routines were not completed as per policy.
Scope: This non-compliance was widespread as the head injury routine according to the Resident Fall Policy was not followed for all six of the residents reviewed during this inspection.
Compliance History: One voluntary plan of correction (VPC) was issued to the home related to the same subsection since April 1, 2019.

(755)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 2021

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8(1).
Specifically, the licensee shall ensure that their Skin and Wound Care Policy regarding the weekly assessment and documentation of altered skin integrity and wounds, as well as care plans for altered skin integrity, is complied with.

To that effect, the licensee shall develop and implement, education, monitoring and remedial processes as follows:

A) Educate all registered staff, including frequently scheduled agency staff, on the licensee's Skin and Wound Care Policy, ensuring to include education on assessments and care planning specific to the Skin and Wound Policy.

B) Ensure that registered staff are completing weekly wound assessments for residents with impaired skin integrity using the licensee's clinically appropriate assessment tool.

C) Ensure that care plans are developed for residents exhibiting impaired skin integrity.

D) Perform weekly audits to ensure that assessments and care planning are occurring as per the licensee's Skin and Wound Care Policy until consistent compliance is achieved.

E) Take immediate corrective action if deviations occur from established Skin and Wound Care policy.

F) A written record must be kept of everything required under (a), (b), (c), (d) and (e).

Grounds / Motifs :

1. The licensee has failed to ensure that the Skin Care Program: Assessment and Care Planning Policy included in the required Skin and Wound Care Program was complied with for three residents.

O. Reg. 79/10 s. 48(1) requires the licensee to have a skin and wound care program developed and implemented within the home to maintain skin integrity and prevent wounds and O. Reg. 79/10 s.30(1) requires that this program include relevant

policies, procedures and protocols to reduce risk and monitor outcomes.

Specifically, the licensee's Skin Care Program: Assessment and Care Planning Policy #NUR 03-01-41 was not complied with.

The policy described that each resident who exhibits skin breakdown and/or pressure and skin injuries must be assessed each week by a member of the registered nursing staff using the Weekly Wound Assessment Tool in Point Click Care (PCC), and that assessments are to be documented. It also described that the skin care routine will be fully documented in the care plan. The care plan will be reviewed quarterly, and as the condition changes. It further described that a resident care plan should reflect the level of risk for skin integrity impairment, interventions related to skin integrity and wound care, and evaluation of strategies.

Two staff members described that weekly assessments of residents exhibiting altered skin integrity would be documented under a skin progress note.

Three resident's health record were reviewed and found that their weekly wound assessments were not being completed using the specified Weekly Wound Assessment Tool in PCC and the resident's plan of care did not describe the resident's wounds, skin care routine, or interventions and treatment related to skin integrity and wound care. Two out of the three residents also did not have a documented weekly wound assessment two times during that time period. A staff member said that one resident's wounds required cleansing a different times depending on their wound condition and that the resident received a Skin Assessment regularly, however this was not always documented. In a period of four months one resident had 17 missing assessments. A staff member confirmed that the Weekly Wound Assessment Tool in PCC should be used to document weekly wound assessments and that the care plan should include residents skin care routine as described in the policy.

Sources:
Reviewed resident's relevant health care records including progress notes, plan of care and skin assessments.
Policies Skin Care Program: Assessment and Care Planning Policy #NUR 03-01-41
Interviews with Acting DOC and three staff members.

An order was made by taking the following factors into account:
Severity: There was minimal risk of harm to three residents by not completing and documenting the appropriate weekly wound assessments and not documenting their skin routines in the care plan as information was not consistent, thorough, and accessible; and skin integrity issues and interventions could be missed.
Scope: This non-compliance was widespread as the skin and wound policy was not followed for all three of the residents reviewed during this inspection.
Compliance History: One voluntary plan of correction (VPC) was issued to the home related to the same subsection since April 1, 2019.

(732)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 2021

Order # / No d'ordre: 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee shall be compliant with LTCHA 2007, s. 8(1).

Specifically, the licensee shall prepare, submit and implement a plan to ensure that there is, an organized program of personal support and nursing services for the home to meet the assessed needs of the residents.

The plan must include but is not limited to how the following assessed needs will be met when the home has a full complement of staff and when personal support and nursing services are understaffed:

A) Perform two person transfers as assessed to meet the needs of the residents.

B) Ensure that all residents are bathed at a minimum of twice weekly.

C) Ensure that all residents receive their assessed toileting, continence, personal and oral care.

D) Assess residents plans of care as required in order to meet their needs.

E) Reinstate an active interdisciplinary team to meet at least quarterly to evaluate the effectiveness of the medication management system and IPAC coordination and implementation of the program.

F) When issues are identified with care not being provided as per the above assessed needs, take immediate corrective action to prevent further occurrence and document the actions taken and any changes made to the plan.

Please submit the written plan for achieving compliance for inspection # 2021-621755-021 to
Manon Nighbor, LTC Homes Inspector, MLTC, by email to:

OttawaSAO.MOH@ontario.ca
by October 15, 2021.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. The licensee failed to ensure the organized program of personal support and nursing services met the assessed needs of the residents.

The home has had a decrease in their human resources, specifically their PSWs and registered staff. Multiple findings of non-compliance identified throughout the inspection made reference to the the lack of personal support and nursing services available to meet the assessed resident needs.

In reference to WN #2, staff members involved explained that for six residents the Head Injury Routine (HIR) assessments were incomplete because they were short registered staff.

In reference to WN #4, wound care was not provided to a resident as indicated by a staff member who described that they were short staffed and did not have a second staff member to assist them. Four residents did not have clear directions of their assessed needs. Staff members said that there was a lack and inconsistency of registered nurses, which up to recently were responsible for updating the resident's plan of care. Another staff member attributed a wound not cleansed due to lack of time as there was no RN on the floor, as confirmed by review of the schedule.

In reference to WN #8, both staff members expressed that baths did not occur due to short staffing. Review of the schedule confirmed that one of those days when a resident did not receive their bath, the unit was short one PSW member.

In reference to WN #12, staff members confirmed that IPAC meetings were not held quarterly as they did not have sufficient staff to allow participation in the meetings.

Sources:
Reviewed relevant health care records including progress notes, plan of care, POC, bathing documentation, skin care assessments, HIR forms, Professional Practice Committee, PAC and IPAC related documents, Staff schedules.
Policies #NUR 05-02-01 and #NUR 03-01-41.
Interviews with fifteen staff members.

An order was made by taking the following factors into account:
Severity: There was actual risk of harm to six residents, by not completing the head

injury routines and other resident's missed care.
Scope: This non-compliance was widespread as the personal support and nursing organized program affects the needs of all residents in the home.
Compliance History: There was no previous non-compliance

(755)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 7 th day of October, 2021 (A1)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by MANON NIGHBOR (755) - (A1)

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