Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

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

Central East District
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Amended Public Report (A2)

Report Issue Date: December 28, 2022	
Inspection Number: 2022-1356-0002	
Inspection Type: Complaint Follow up Critical Incident System	
Licensee: AXR Operating (National) LP, by its general partners c/o Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600 Mississauga ON L4W0E4	
Long Term Care Home and City: Winbourne Park, Ajax	
Lead Inspector Holly Wilson (741755)	**Inspector Digital Signature** Holly N Wilson Digitally signed by Holly N Wilson Date: 2023.03.13 09:05:44 -04'00'
Additional Inspector(s) Susan Semeredy (501) Sarah Lee (735818)	

AMENDMENT INSPECTION REPORT SUMMARY

This licensee inspection report has been revised to reflect a request by the home to extend the Compliance Due Date to April 10, 2023.

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
November 16-18, 2022
November 21-25, 2022
November 28-December 2, 2022

The following intake(s) were inspected related to the prevention of abuse and neglect

- Intake: #00003024
- Intake: #00003447
- Intake: #00003483

- Intake: #00004069
- Intake: #00004584
- Intake: #00005091
- Intake: #00013227

- Intake: #00005254 Follow-up to CO#001 from inspection #2022_673672_0006 / 021202-21 regarding s. 15. (2)
- Intake: #00007042 Failure/breakdown of major equipment
- Intake: #00008701 Complaint regarding the prevention of abuse and neglect, maintenance, housekeeping, dining and snack services, and resident care and support services.
- Intake: #00011764 related to falls prevention and management

The following intakes were completed in the Critical Incident System Inspection and related to Falls Prevention. The program was inspected November 16-December 2, 2022, under inspection #2022-1356-0002, Intake #00011764, with the following areas of non-compliance identified: Written Notification with: O.Reg. 246/22, s. 54 (1) and O.Reg.246/22, s. 115(5) 2. ii

- Intake #00003446
- Intake #00003449
- Intake #00003469
- Intake #00008622
- Intake #00001320
- Intake #00003046
- Intake #00002695
- Intake #00002960
- Intake #00002987
- Intake #00005103
- Intake #00003446

Previously Issued Compliance Order(s)

The following previously issued Compliance Order was found to be in compliance: Order #001 from inspection #2022_673672_0006 related to LTCHA, 2007, s. 15 (2) was inspected by (741755)

The following **Inspection Protocols** were used during this inspection:

Prevention of Abuse and Neglect
Safe and Secure Home

Skin and Wound Prevention and Management
Housekeeping, Laundry, and Maintenance Services
Infection Prevention and Control
Responsive Behaviors
Resident Care and Support Services
Continence Care
Food, Nutrition and Hydration
Residents' Rights and Choices
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Maintenance services

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 96 (2) (d)

The licensee has failed to ensure that procedures were developed and implemented to ensure that all toilets and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

Rationale and Summary

During a tour of the home, corroded shower racks were observed on the walls of the shower areas in multiple spa rooms. In the spa room, the toilet seat was observed to be completely detached from the toilet and was placed beside the toilet on the floor. In a room, the toilet bowl tank cover was missing and was replaced with a rectangular plastic covering that did not cover the entire tank.

According to the contracted service provider's environmental services policies, there were no written procedures that were developed and implemented to ensure that toilets and washroom fixtures and accessories were maintained and kept free of corrosion and cracks. The ESM stated that maintenance for plumbing, toilet, and washroom fixtures and accessories were addressed as part of the remedial maintenance program, which was dependent on staff reporting the items through their maintenance reporting system. On November 16, 2022, the ESM was made aware of these items by the inspectors. On November 23, 2022, during a tour of the home on conducted with the full time ESM and the District

Manager, these deficiencies remained outstanding.

There was a potential risk to resident safety when the toilets and washroom fixtures and accessories were not maintained and kept free of corrosion and cracks.

Sources: Observations, interview with ESM, Contract Service Provider Environmental Services Manual

[735818]

WRITTEN NOTIFICATION: Housekeeping

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (a) (ii)

The licensee has failed to ensure procedures were developed and/or implemented for the cleaning of the home for common areas and staff areas, including the floors, carpets, windows, furnishings, and wall surfaces in the dining rooms, resident common areas, spa rooms, and janitors' closets.

Rationale and Summary

The housekeeping program for the home was managed by a contracted service provider. The Environmental Services Manager (ESM) and Environmental Services (EVS) District Manager for the contracted service provider confirmed that their policies and procedures were to be followed.

1. According to the contracted service provider's procedure, Vacuuming Carpet or Hard Floor Surface, ES-C-20-20, last revised February 2022, staff were to vacuum corners and edges using the designated attachment/crevice tool. During the inspection, the hallways were observed to have an accumulation of visible dirt on the carpeted areas near the baseboards and corners of the walls throughout all four resident home areas. Based on the observations, the cleaning procedures were not being implemented. The EVS District Manager acknowledged the neglect in housekeeping practices and confirmed that corners and edges were to be included when vacuuming carpets in the hallways.

2. According to the contract service provider's procedure, Contract Spec-Resident Dining Rooms, G-15-45, last revised February 2022, the dining room chairs, and table legs were to be checked daily and spot cleaned as required. Windowsills were to be spot cleaned daily, and hand dusted using a damp cloth weekly. High dusting in the dining room including vents were to be done weekly. During the inspection, the dining rooms were observed to have an accumulation of dirt, dust, and food particles around the

baseboards and in the corners. Stool legs and table legs were observed to be visibly soiled. Windowsills were observed to have a buildup of food debris. Food splatters were observed on the walls in the dining room and on the walls and doors near the dining room. An accumulation of dust was on observed on the air supply diffuser, on the ceiling area around the air supply diffuser, and on the light sconces over the counter in the serveries. Based on the observations, the cleaning procedures were not being implemented.

3. According to the contracted service provider's procedure, Contract Spec-Washrooms, Tub, Shower Rooms, G-15-40 last revised February 2022, all floors were to be dust mopped daily and damp mopped daily. There were no procedures developed for the routine cleaning of the shower bench in the Spa rooms. During the inspection, in the spa rooms, the shower floor areas were observed to be dirty and had an accumulation of hair in the drain cover. In one spa room, a pile of dirt and ants were observed in the corner of shower area. The shower benches attached to the walls were observed to be visibly soiled underneath the bench. The District Manager acknowledged that the shower benches were the responsibility of housekeeping staff to clean. Based on the observations, the cleaning procedures were not being implemented.

4. According to the contracted service provider's procedures, Contract-Spec-Lounges and Sitting Rooms, G-15-20, last revised February 2022, Contract Spec-Lobbies and Corridors, G-15-15, last revised February 2022, and Contract Spec-Entrances and Main Lobby, G-15-10, last revised February 2022, required the home to complete high-dusting on a weekly basis in the lounges, sitting rooms, lobbies, corridors, entrances, and main lobby, including high dusting of the vents. During the inspection, an accumulation of dust was observed on the ceiling grilles located in resident common areas and in the hallways throughout the home. Dust that was propelled from the vent was observed on the walls directly across from the vent grilles. Based on the observations, the cleaning procedures were not being implemented. In the contracted service provider's procedure, Vent cleaning, ES-C-10-85, last revised February 2022, staff were also to complete high dusting of the vent as per the home's schedule. The home's deep cleaning schedule identified that the vents were to be deep cleaned every 12 months by the heavy-duty cleaner. The heavy-duty cleaner stated that they were not assigned or trained to do so.

5. According to the contracted service provider's procedure, Contract Spec-Main Kitchen, and Serveries (General), G-05-05, last revised February 2022, the designated janitor closets were to be maintained by the designated department. During the inspection, the janitor's closets used by the dietary aides on the resident home areas were not maintained in a sanitary condition. In one janitor's closet, a black substance was observed on broken furniture or equipment that was placed in the mop sink. In another janitor's closet, the mop sink was observed to have a layer of accumulated sediment from dirty water and garbage which clogged the drain cover. A Dietary Aide (DA) acknowledged that they used the closet for chemicals and the sink and were responsible for cleaning the closet. A DA acknowledged that they

used the closet for accessing the necessary chemicals but was not responsible for cleaning it. The Quality Services Manager, acting as an interim Food Services Manager, acknowledged the closet was not maintained in an acceptable condition but was unsure who was responsible for cleaning the closet. Based on the observations and interviews, the cleaning procedures were not being implemented.

6. In multiple windows throughout resident common areas and in resident rooms, an accumulation of dirt, debris, dead insects, webs, and garbage were observed in windows between the window screen, frame, and pane. ESM acknowledged that the cleaning of the windows was a part of the housekeeping program. According to the contract service provider's procedures, Quarterly Routine-Windows, ES 75-20, last revised February 2022, and Interior Window Cleaning, ES-C-10-90, last revised February 2022, the home had procedures to ensure that all windows and their components are in good repair and to clean the window frame, ledges, and glass components of the interior side of the window. However, procedures were not developed for the cleaning of the window between the window screen, frame, and glass where the build-up of dirt, debris, dead insects, webs, and garbage was observed.

The ESM reported that housekeeping audits in general areas were to be conducted daily. On the housekeeping audit, completed on November 22, 2022, vent cleaning was identified as a non-satisfactory item; however, no comments or required corrective actions were documented. Other housekeeping items, including the sanitary condition of the drains, floors, walls, windows, windowsills, and baseboards throughout common areas, were identified as satisfactory. However, these items were identified as deficiencies on the initial tour by the inspector on November 18, 2022, and during the tour of the home with the EVS District Manager and ESM on November 23, 2022.

ESMs' and the EVS District Manager for contracted services acknowledged that housekeeping practices were not being maintained within the home. There was a potential risk for the spread of infectious agents when housekeeping procedures were not developed and/or implemented in the home.

Sources: Observations, Contract Service Provider Environmental Services policies and procedures, interviews with staff, housekeeping audits, and interviews with ESM and EVS District Manager

[735818]

WRITTEN NOTIFICATION: Housekeeping

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 93 (2) (b) (iii)

The licensee has failed to ensure that procedures were implemented for the cleaning and disinfection of contact surfaces using, at a minimum, a low-level disinfectant in accordance with evidence-based practices.

Rationale and Summary

The home's housekeeping program for the home was managed by a contracted service provider. According to the contracted service provider's policy, 10-step Cleaning and Disinfecting Method ES-C-05-15, last revised February 2022, staff were expected to clean and disinfect horizontal and vertical high touch surfaces during the daily cleaning of resident rooms. The home's daily resident room cleaning routine also identified that high touch surfaces were to be cleaned and disinfected daily.

Two housekeeping staff acknowledged that they were responsible for the daily cleaning and disinfection of high-touch surfaces in resident rooms. Both staff reported that they were unable to complete the daily cleaning and disinfection of high touch surfaces in resident rooms since they were short-staffed. When there was no housekeeping staff assigned to clean centre-core areas, the centre-core cleaning duties were assigned to light-duty housekeeping staff. Housekeeping staff reported that they did not have the time to complete their full list of daily assigned duties when also required to complete centre-core cleaning duties on their shift.

There was a potential risk for the transmission of infectious agents to residents and staff when high-touch surfaces are not cleaned and disinfected daily.

Sources: 10-step Cleaning and Disinfecting Method Procedure (ES-C-05-15, last revised February 2022), Daily Resident Room Cleaning Routine Checklist, interviews with staff

[735818]

WRITTEN NOTIFICATION: Pest control

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 94 (1)

As part of organized programs of housekeeping and maintenance services under clauses 19 (1) (a) and (c) of the Act, the licensee has failed to ensure that an organized preventative pest control program at the home was complied with.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that an organized preventative pest control program is in place at the home and must be complied with.

Specifically, the contract service provider's procedure, Infection Pest Control, ES H-20-00 last revised February 2022, required the implementation of effective preventive maintenance programs as part of the pest control program, including to inspect all baseboards, walls and corner openings. There was no written preventative maintenance procedure or schedule to inspect baseboards, walls, and corner openings.

During the inspection, the doors that led outside on the balcony on the second floor, in the main lounge area, and in the receiving area/loading dock were observed to have gaps when the door when fully closed which could allow the entry of pests. The receiving area/loading dock door was missing the door plate, which left a large gap between the door and the raw floor. This was identified by the pest contract service provider and was classified as an "immediate action findings" related to structural concerns in pest control records since July 27, 2022. This concern was repeated as an "immediate action finding" in the September 23, October 24, and November 10 pest control records.

There was a potential risk of pest infestation when the home did not follow their pest control program to include preventative maintenance and did not conduct the remedial maintenance based on the recommendations from their licensed pest control provider.

Sources: Observations, interview with ESM, Infection Pest Control Policy & Procedure (ES H-20-00, last revised February 2022), Pest contact service provider reports

[735818]

WRITTEN NOTIFICATION: Maintenance services

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 96 (1) (b)

The licensee has failed to ensure that schedules and procedures were in place for remedial and preventive maintenance and were complied with.

Rationale and Summary

The maintenance program for the home was being managed by a contract service provider.

The contract service provider's preventative maintenance system and schedule, ES E-05-05, last revised February 2022, required preventative maintenance to be carried out on the planned schedule: daily, weekly, monthly, quarterly, semi-annually, and annually in order to ensure the residents and staff environment was well maintained. According to the contracted service provider's environmental services policies and the preventative maintenance schedule, there were no written procedures in place to guide designated staff in their role in conducting preventive and remedial maintenance related to the condition of walls, baseboards, ceilings, floors, and working light fixtures.

ESM stated that maintenance issues were to be reported by staff through their maintenance reporting system but acknowledged that not all maintenance issues were being reported by staff. ESM reported that maintenance issues were also to be identified during their daily rounds of the home; however, there was no documentation of the audits, or the maintenance concerns identified by the audits.

During the inspection, the following conditions was observed:

Walls and baseboards: No procedure or confirmed schedule was in place to address the condition of the walls and baseboards in the home. Corner guards were observed to be in disrepair outside of resident rooms. Resident room walls were observed to be in disrepair, with an abundance of scratches and holes. Damaged plaster was observed on the resident bathroom door frames which led to exposing the metal door frame. Resident room doors were observed to be scratched. Vinyl baseboards were missing and in disrepair in the corners of resident rooms and bathrooms. In the dining rooms, walls and wall guards were damaged and scratched. Baseboards were observed to be peeling and bubbling. In one dining room, papers were stuffed into a hole in the wall. In a resident resting area, a yellow dust was observed along the baseboard between the carpet and the baseboard. The area emitted a smell of urine. Staff had reported that a resident had previously used this area for urination. The baseboards appeared to be disintegrating causing a gap between the baseboard and the carpet along the walls in this area.

Ceilings: No procedure or confirmed schedule was in place to address the condition of the ceilings in the home. On a resident home area, a cut-out ceiling area was observed in the wellness room due to unfinished repairs from previous water damage. In the public washrooms within in two resident home areas, paint was observed to be peeling off the high walls and ceilings due to water damage. Outside one of the dining rooms, a large area of the ceiling paint was observed to be peeling due to water damage.

Floors: No procedure or confirmed schedule was in place to address the condition of the floors in the home. The floor in the wellness room was observed to be cracked and peeling that exposed the concrete underneath. The concrete flooring around the drain in the garbage room was observed to be crumbling and in disrepair. The drain cover in the garbage room was observed to be completely separated from drain underneath.

Working lights: No procedure or confirmed schedule was in place to ensure that all light fixtures were operating as intended. Multiple pot lights were not working as intended throughout the home in resident rooms, in resident bathrooms, and in public washrooms. Light sconces were missing throughout the home, including in the Spa rooms in multiple resident home areas and in a dining room.

Furthermore, in accordance with O. Reg 246/22 s. 11 (1) (b), the licensee was required to ensure schedules and procedures in place for remedial and preventive maintenance were complied with.

According to the contract service provider's procedures, Exterior Grounds-General Procedure, E-90-05, last revised February 2022, daily inspections for the front entrance, courtyards, and patio area were to be conducted where items are to be identified for repairs and removed if broken. During the inspection, a fence erected around building equipment that was in an outdoor resident area was half-standing and falling at a 45-degree angle, allowing residents to access the building equipment if they were outside. ESM reported that they were not aware of this disrepair in the resident outdoor areas while conducting their daily inspections of the courtyards.

According to the contract service provider's procedures, Quarter Routine Painting Procedure, ES 75-15, last revised February 2022, painting checks were to be conducted monthly which required the designate staff to inspect all resident rooms, dining rooms, corridors, etc. and follow-up with touch up plaster and painting where required. All areas of the home were to be touch-up painted at least quarterly and recorded on the Painting Log Form. During the inspection, paint was observed to be chipping away from baseboards in the hallways. Numerous areas within common areas and in resident rooms requiring touch ups, repairs, and painting were observed without being able to confirm when they were last painted or repaired. ESM acknowledged that there was no documentation for the painting audits completed or for any actions taken as a follow-up to the areas identified requiring touch-ups, repair, or painting, as required by the service contract provider's procedures.

ESMs' and the District Manager of the contract service provider acknowledged the disrepair noted throughout the home. There was a potential risk to resident safety when the home did not implement procedures for preventative and remedial maintenance of the walls, baseboards, ceilings, floors, lighting, and exterior grounds.

Sources: observations, interview with ESMs and District Manager, housekeeping audits, Preventative Maintenance System and Schedule (ES E-05-05, revised February 2022), Quarterly Routine Painting Procedure (ES 75-15, revised February 2022), Exterior Grounds General Procedure (E-90-05, revised February 2022), Environmental Services Manual.

[735818]

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 3 (1) 4.

The licensee has failed to ensure that a resident's right to be properly groomed and cared for in a manner consistent with their needs was fully respected and promoted.

Rationale and Summary

The home received communication that the care provided to a resident was inappropriate. The resident was known to have triggers for responsive behaviors. Even though the resident was complaining, a PSW carried on giving care without acknowledging the resident's concerns. The PSW acknowledged there were insufficient care items available. The ED confirmed the PSW did not provide care consistent with the home's expectations and was re-educated.

Failing to provide care in a proper manner consistent with their needs violated a resident's right to be properly groomed and cared for.

Sources: CIR, a resident's care plan and interviews with a PSW, and the ED.

[501]

WRITTEN NOTIFICATION: Dining and snack service

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O. Reg. 79/10, s. 73 (1) 10.

The licensee has failed to ensure that a PSW used proper techniques to assist a resident with eating.

Rationale and Summary

A Recreation Aide was informed that a PSW forcefully fed a resident during a meal. The resident was refusing and the PSW used an inappropriate utensil. The ED confirmed that the PSW did not use proper techniques to feed the resident.

Failing to ensure staff used proper techniques to feed a resident put the resident at risk to choke.

Sources: CIR, the home's investigation notes, and interviews with Recreation Aide, PSW and the ED.

[501]

WRITTEN NOTIFICATION: Report re Critical Incident

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 115 (5) 2. ii.

The licensee failed to ensure that reports made to the Director included the names of any staff members who discovered the incident.

Rationale and Summary

A CIR related to fall and injury of a resident was submitted to the Director. The CIR did not include the

name of the staff member who discovered the fall incident. The post fall assessment indicated the resident was found lying on the floor beside their bed by a PSW. The DOC confirmed that this report did not include the name of this PSW.

Sources: CIR, a resident's clinical record and interview with the DOC.

[501]

WRITTEN NOTIFICATION: Falls prevention and management

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 54 (1)

The licensee has failed to comply with the strategy to reduce or mitigate falls for a resident.

Rationale and Summary

In accordance with O. Reg 246/22 s. 11 (1) (b), the licensee is required to ensure that the falls prevention and management program must, at a minimum, provide for strategies to reduce or mitigate falls.

Specifically, the staff did not comply with the home's internal policy titled "Post-Fall Management" that indicated an interdisciplinary team huddle is to be conducted on the same shift that the fall occurred. This team huddle is to address specific questions to collect the information needed to conduct a root cause analysis of the fall.

A resident had a fall with an injury. The post-fall assessment was completed by the RN who responded to the fall. The section that was to include details of the post-fall huddle was blank. A resident had previous falls. Several of the post-fall assessments did not include details of a post-fall huddle. The Lead for the Falls Prevention and Management Program stated that a post-fall huddle should be documented and should include who was there, what was discussed, what interventions were in place at the time of the fall and what interventions might be considered to prevent further falls.

Failing to perform post-fall huddles put the resident at risk for potential further falls.

Sources: CIR, a resident's clinical record, the home's fall prevention and injury reduction policy and procedure, and interviews with RN, RPN, and other staff.

[501]

WRITTEN NOTIFICATION: Registered dietitian

NC #0010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 80 (2)

The licensee has failed to ensure that a registered dietitian (RD) who was a member of the staff of the home was on site a minimum of 30 minutes per resident per month during the month of November 2022.

Rationale and Summary:

The home had a census of approximately 109 residents during the month of November and required a registered dietitian to be on site for at least 54.5 hours. A review of the hours recorded for the office manager by the RD indicated they were on site and provided virtual care for a total of 49 hours. The ED indicated there were two hours missing for the last day in November 2022 so the total would have been 51 hours. The ED further indicated that approximately half of those total hours would have been virtual and not on site which did not meet the minimum time. Therefore, on site hours would be 25.5 hours.

Failing to ensure an RD was on site for the required time put residents at nutritional risk.

Sources: Email communication between the office manager and RD and an interview with the ED.

[501]

WRITTEN NOTIFICATION: Policy to promote zero tolerance

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 20 (1)

The licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Rationale and Summary:

The home's policy stated that in cases of abuse, the home was to ensure the safety and comfort of the abuse victim by taking steps to provide for their immediate safety and well-being. Complete full assessments to determine the residents needs and document them on the resident's care plan. Assessed by their attending physician and appropriate interventions offered but not limited to: Counselling services offered through a Social Worker, CCAC Social Work or other services as available in some cases to ensure to preserve potential evidence. Staff are to ensure that: consent is obtained to take pictures of any injuries or evidence, accurate detailed descriptions of injuries/condition are documented in the resident's chart, ensure that the resident, their clothing, and linens are not washed to preserve evidence.

An RN documented that a PSW witnessed an incident of resident-to-resident abuse. The resident's physician was notified, and no orders were received. On a later date, the physician reviewed resident and no documentation was identified related to the incident of abuse.

Failing to comply with the home's policy put a resident's physical and emotional health at risk.

Sources: CIR, Residents Abuse Policy, and Procedure (Admini-P10-ENT revised March 31, 2022), a resident's clinical record, interviews with DOC, and the RN.

[741755]

WRITTEN NOTIFICATION: Doors in a home

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 12 (1) 3.

The licensee has failed to ensure that a door leading to non-residential area was kept closed and locked.

Rationale and Summary:

On November 29, 2022, door 2C-13 was found not properly closed and unlocked. This room lead to the garbage and laundry chutes. The Executive Director (ED) observed and confirmed that this door should be closed and locked.

Failing to ensure that this door is closed and locked posed a risk that residents could enter and potentially injure themselves.

Sources: Observation and an interview with the ED.

[741755]

Written Notification Duty to protect

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: LTCHA, 2007 S.O. 2007, c.8, s. 19 (1)

A) The licensee has failed to protect a resident from abuse.

Rationale and Summary

An incident occurred between two residents. Both residents were separated immediately. The DOC confirmed one resident was not protected from abuse by another resident.

Failing to provide a resident with treatment and services jeopardized their health and well-being.

Sources: CIR, a resident's clinical record, interviews with DOC, and the RN.

[741755]

B) The licensee has failed to ensure that a resident was not neglected by an RPN.

Rationale and Summary

A resident had a history of pain and received scheduled and as needed pain medication. The resident rang the call bell twice in the morning and requested if they could have something for pain. The home's investigation notes indicated the RPN was advised of the resident's request but failed to administer any pain medication in a timely manner.

Failing to provide the resident with treatment and services jeopardized their health and well-being.

Sources: The home's investigation notes, resident's clinical record, interviews with PSWs, and other staff.

[501]

COMPLIANCE ORDER CO #001 Accommodation services

NC #014 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: FLTCA, 2021, s. 19 (2) (c)

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

Specifically, the licensee shall:

1. Have a professional assessment conducted to identify the cause and to determine the repairs required for the warped/bulging wall and splitting baseboard in the Harwood Lane entrance corridor. Document the assessment results, who conducted the assessment, and the date of the assessment.
2. Complete the repairs identified in the professional assessment to ensure that the home is maintained in a safe condition and in a good state of repair.
3. Replace or repair all baseboards in disrepair in the home, including but not limited to the baseboard in the Hardwood Lane living room.
4. Repair all existing cut-out wall and ceiling holes throughout the home, including but not limited to the kitchen and resident common areas.
5. Develop and implement a written preventive maintenance procedure and schedule to ensure that the building interior is maintained in a safe condition and good state of repair that includes but is not limited to the following: the frequency of visual inspections of ceilings, walls, baseboards, and other surfaces in the home for moisture damage, cracks, bubbling, peeling paint, stains and other issues indicative of poor maintenance; whether the inspection of the building interior will be completed by external contractors or knowledgeable home employees or both; how the results of the inspections will be documented; who will review the inspection results; who will take actions required when deficiencies are identified; and the time frame for remedial action.

Grounds

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

Rational and Summary

The maintenance program for the home was being managed by a contract service provider.

During the inspection, the following conditions were observed throughout the home:

A complaint was received by the Ministry of Long-Term Care regarding a ceiling being in disrepair. In a resident's bathroom, a ceiling tile located above the resident's toilet was observed to have extensive water damage. There were multiple large cracks in the ceiling tile which created a hole above the toilet. The exhaust vent grille was partially detached from the ceiling tile. The light fixture was attached to the hanging part of the ceiling tile. The ESM acknowledged the disrepair and the risk to the resident. The ceiling tile was not repaired until November 18, 2022, when brought forth again by the inspector.

In Harwood Lane, the baseboard along a wall in the Living Room was observed to be splintering and detaching from the wall. The paint on the baseboard was observed to be bubbling and peeling. An unknown black substance was observed behind the detaching baseboard. Along another wall near the entrance of Harwood Lane, a baseboard was observed to be splitting, which produced a significant gap between the baseboards. The affected wall was observed to be bulging and warped outwards towards the corridor. The paint on the wall and the baseboard was observed to be bubbling and peeling. The Environmental Services (EVS) District Manager for the contract service provider acknowledged the state of the wall and baseboards and recognized that an assessment would need to be conducted to identify the cause and to determine the repair required.

In a resident sitting area in Lakeridge home area, a cut-out square hole (approximately 30cm x 30cm) was observed in the ceiling; along the ceiling edge of the hole, an unknown black substance was observed. The EVS District Manager acknowledged the disrepair and black substance in the ceiling and noted that it was due to uncompleted repairs from previous water damage repairs this year.

In the kitchen, large cut-out areas were missing from the wall and ceiling as a result of uncompleted repairs. A large cut-out area in kitchen ceiling (approximately 76 cm x 38 cm) was open with wires hanging and exposed insulation above the food preparation area. Another large cut-out area in the kitchen wall by dishwashing area (approximately 120cm x 30cm) was open and exposing pipes. Underneath the dishwashing area, a large cut-out area of the kitchen wall was observed to be open with exposed sprayed foam insulation and exposed wires. There were no barriers in place over the cut-out wall or ceiling areas, which left insulation, wiring, and pipes exposed to the food preparation and

dishwashing areas. At the base of a kitchen wall, the wall was observed to be crumbling and in disrepair, creating a hole (approximately 18cm x 11cm); within this hole, an exposed corroded metal corner beam and an unknown black substance on the broken wall was observed.

ESM's and EVS District Manager for the contract service provider acknowledged the disrepair observed throughout the home. There was a potential risk to resident safety when the built environment was not maintained in a good state of repair, including a falling ceiling tile due to water damage, a warped/bulging wall, an unknown black substance behind and between the baseboards and on the ceiling in resident common areas, and the potential contamination of food and food contact surfaces with exposed insulation in the ceiling and walls and with unknown black substance on the broken walls in the kitchen.

Sources: Observations, interviews with ESM's and EVS District Manager

[735818]

This order must be complied with by April 10, 2023.

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;

(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier 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
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board

Attention Registrar
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
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.