Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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

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

Toronto Service Area Office
5700 Yonge Street 5th Floor
TORONTO ON M2M 4K5
Telephone: (416) 325-9660
Facsimile: (416) 327-4486

Bureau régional de services de Toronto
5700, rue Yonge 5e étage
TORONTO ON M2M 4K5
Téléphone: (416) 325-9660
Télécopieur: (416) 327-4486


## 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 |
|---|---|---|---|
| Jan 22, 2021 | 2020_780699_0014 (A4) | 006859-20, 008209-20, 010332-20, 010770-20, 011235-20, 012616-20, 013288-20, 015463-20 | Complaint |

### Licensee/Titulaire de permis

2063414 Ontario Limited as General Partner of 2063414 Investment LP
302 Town Centre Blvd. Suite 300 Markham ON L3R 0E8

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

Woodbridge Vista Care Community
5400 Steeles Avenue West Woodbridge ON L4L 9S1

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

Amended by PRAVEENA SITTAMPALAM (699) - (A4)

## Amended Inspection Summary/Résumé de l'inspection modifié

**Compliance due dates (CDD) for Compliance orders #002 and #003 extended to March 15, 2021.**

**Issued on this 22nd day of January, 2021 (A4)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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

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


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Amended by PRAVEENA SITTAMPALAM (699) - (A4)

## 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): June 2, 3, 4, 7, 8, 9, 10,**

**11, 15, 16, 17, 18, 19, 22, 23, 24, 25, 26, 30, July 2, 3, 7, 8, 9, 2020; off-site: June 5, 12, 29, July 6, 10, 13-17, 20- 24, 27-31, August 3-7, 10-14, 2020.**

**The following intakes were completed during this inspection: Logs #010332-20, #015463-20 [CIS 2945-000024-20] (related to staffing, neglect, and protocols), #011235-20 (related to anonymous concerns/neglect), #010770-20 (related to daily care, medication management), #008209-20 (related to resident assessment concerns), #013288-20 [CIS 2945-000021-20] (related to resident assessment concerns), #006859-20 (related to change in condition) and #012616-20 (related to following protocols and care concerns).**

**For s. 19: Additional evidence supporting this non-compliance was identified in inspection reports 2020_780699_0011, 2020_780699_0012, and 2020_780699_0013, that was inspected concurrently with this inspection.**

**For r. 229 (5) (a): Additional evidence supporting this non-compliance was identified in inspection reports 2020_780699_0012, and 2020_780699_0013, that was inspected concurrently with this inspection.**

**During the course of the inspection, the inspector(s) spoke with the previous Executive Director, current Executive Director (ED), Medical Director, Primary Care Physician, previous Director of Care (DOC), the current Interim Director of Care (IDOC), Nurse Practitioner (NP), Supporting DOC (SDOC), Associate Director of Care (ADOC), Nurse Managers (NM), Regional Director - Marquise (RDM), Director of Environmental Services (DES), Housekeeping**

**Supervisor, Food Service Manager (FSM), Clinical Care Partner, Talent Acquisitions Partner, York Region Public Health Inspector (YRPHI), Nursing Agency, housekeeping staff, activation staff, scheduling clerk, dietary staff, registered staff (RN/RPN), personal support workers (PSWs) and substitute decision-makers (SDMs).**

**During the course of the inspection, the inspectors conducted multiple tours of the home, observations of the home including screening process and protocols, resident home areas, resident and staff interactions, resident to resident interactions, reviewed clinical health, treatment and medication administration records, staffing schedule and the staffing plans, internal investigation notes and relevant home policies and procedures.**

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

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Dining Observation**
**Hospitalization and Change in Condition**
**Infection Prevention and Control**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**
**Sufficient Staffing**
**Training and Orientation**

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

- **15 WN(s)**
- **4 VPC(s)**
- **10 CO(s)**
- **3 DR(s)**
- **0 WAO(s)**

| NON-COMPLIANCE / NON - RESPECT DES EXIGENCES | |
|---|---|
| Legend<br><br>WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | Légende<br><br>WN – Avis écrit<br>VPC – Plan de redressement volontaire<br>DR – Aiguillage au directeur<br>CO – Ordre de conformité<br>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.)<br><br>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.)<br><br>Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. |

**WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).**

**Findings/Faits saillants :**

1. The licensee had failed to ensure there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present unless there was an allowable exception to this requirement.

Record review of the long-term care home's staffing schedule for the months of April, May, June and July 2020, indicated the home did not have a registered nurse (RN) on duty and present in the building for eights shifts. During these shifts, the scheduling clerk did not indicate that an extra RPN was scheduled to cover the role of the RN on duty.

This information was verified by the home's Scheduling Clerk #149 and ED #101 on July 30, 2020. ED #101 also added the following statements related to the Nurse Manager (NM/RN) role in the home: If an RN is working on the unit, the RN can still be the nurse in charge. Also, pre-outbreak the RN on night shift also covered the first floor and was in-charge. The times when an RN is not in the building, the process was to ensure that there was a RN or the Director of Care (DOC) available on call to support clinical decision-making and risks. There would also be a designated RPN in charge who would take the lead to support with acquiring resources as needed, contacting the RN on call, on call manager in some cases and/or DOC/ED.

Therefore, the licensee has failed to ensure at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times.

***Additional Required Actions:***

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

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001**

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**WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services**

**Specifically failed to comply with the following:**

**s. 15. (2) Every licensee of a long-term care home shall ensure that,**
**(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).**
**(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).**
**(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).**

**Findings/Faits saillants :**

The licensee has failed to ensure that furnishings and the home were maintained in a good state of repair.

i) On June 17, 18 and 19, 2020, a tour of the home was conducted and noted numerous instances of water damaged ceiling tiles throughout the home were not maintained. In some cases, the ceiling tiles were missing, badly stained, with or without water-logging or painted over with white paint. The water damaged tiles also presented an infection control risk as they are a suitable environment to support growth of mold. Damaged ceiling tiles were found on all floors as well as in the laundry room.

ii) During the tour of the home there were areas of damaged flooring throughout the home and on all floors as follows:

On the first floor, flooring was found to be damaged in one stall of the female staff change room, and in one unit corridor, flooring baseboard was loose with a large gap present. In the laundry room, flooring was badly damaged both on the "clean side" and "dirty side". In the kitchen, flooring was damaged near the walk-in

fridge/freezer. Outside of an identified room, in the hallway, flooring was damaged along the centre line.

In the second floor hallway, flooring was cracked at the centre line running from the nursing station to the fire doors, as well as floor tiles broken across from the elevators.

On the third floor, it was noted in an identified room that the washroom floor covering was pushed in, representing a possible infection control risk. In the Soiled Utility room across from an identified room, baseboards were pulling away from the wall leaving gaps, representing a possible infection control risk.

On the fourth floor, in three different resident rooms, the baseboards were pushed in and noted to be an infection control risk. In Unit 4B, North Lounge wall baseboards had numerous gaps, representing an infection control risk.

iii) Dirty windows were noted on all floors in the home. In two rooms, there were cuts observed in the screens which would allow insects to enter those rooms.

iv) General un-repaired damage in residents' rooms and common areas noted as follows:
On the first floor, damaged wall was observed outside an identified room. In another room, the washroom door frame was badly chipped. The tub room toilet seat surface was rough for residents' to sit on; and the door frame protection had a chunk missing at the bottom (inside the room), and a sharp piece sticking out was an injury risk.

On the third floor, there were dents in the walls in a room, and another room only had one of two light bulbs working in the washroom. In the Soiled Utility room, the covering was peeling from the wall which was an infection control risk. There were numerous holes in the wall, and the baseboards were pulling away from the wall leaving gaps, and holes left in the wall as a result of a previously removed dispenser.

On the fourth floor, North residents' washroom, the wall covering was broken along the seam; and in the North residents' lounge, the area of walls close to the lounge was damaged, and white paint was applied but not the matching color. In the Dining room, the wall protection was peeling from the wall, and there were metal studs exposed. In the South residents' washroom, the wall was damaged

and the repair was incomplete. The toilet tank cover was broken.

v) Damaged nursing stations were noted throughout the home with the wood showing where protective coverings were worn, and some areas were covered with duct tape which represented an infection control risk.

vi) The home recently hired a new Director of Environmental Services (DES), therefore an interview was conducted with ED #101 related to the Inspector's observations. ED #101 confirmed that there was no work orders entered into electronic maintenance system for completion related to repairing or replacing flooring in the past year. During an interview, DES #154 indicated that the focus right now was to deal with the outbreak; and that once the outbreak was declared over, then attention would be turned to dealing with the maintenance backlog.

***Additional Required Actions:***

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

**(A4)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002**

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**WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect**

**Specifically failed to comply with the following:**

**s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).**

**Findings/Faits saillants :**

(A1)
1. The licensee has failed to ensure residents #002, #003, #009, #006 and #014 were protected from neglect by the licensee or staff in the home.

For the purposes of definition 'neglect' in subsection 5 of Ontario Regulation 79/10 means, the failure to provide a resident with the treatment, care, service or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Ministry of Long-Term Care (MLTC) received a complaint, related to staffing shortages, outbreak management, lack of Personal Protective Equipment (PPE) for staff and care requirements of residents not being met.

An identified communicable disease outbreak was declared at the home by Public Health. Ongoing concerns regarding the management of the outbreak were being reported to the MLTC which included not managing residents who were wandering around the units potentially spreading the infection.

Residents #003 and #009 had a history of a specified responsive behaviour prior to the outbreak.

a. On an identified date, documentation in the residents clinical record indicated that staff observed the resident walking up and down the hallway. The resident was then observed grabbing a co-resident's walker in their room and staff had to intervene to minimize the risk of the co-resident falling.

Documentation in resident #003's electronic health records indicated on day two, the resident had a symptom of infection and was administered a specified medication. There were residents on the unit that had been confirmed positive for an infection at this time. The resident continued to exhibit a specified behaviour and did not stay in their room. The nurse manager was informed; however, no interventions were implemented.

On day three, the resident was tested for the presence of an infection.

On day four, documentation indicated that the resident was in contact with residents who were positive for an infection. The intervention documented was to

keep monitoring.

On day five, the test results received showed resident #003 was positive for the identified infection.

On day 10, NP #115 ordered a specified treatment for resident #003 due to their poor intake.

On day 11, resident did not receive their specified treatment due to a lack of availability of supplies on the unit to start this treatment.

During an interview, NP #115 stated that they notified ED #100 on day 12 that supplies were not available for the specific treatment to be administered, and that the ED responded that supplies were available but that they were stored in the boardroom. According to the NP, the ED also indicated that the RPN should have contacted the Nurse Manager (NM) to obtain the supplies.

NP #115 stated that during one of their on-site visits, they observed that there was a shortage of staffing, staff were too busy and should have had supplies available on their units, and that not all staff were aware of the process to access supplies due to little to no orientation.

During an Infection Prevention and Control (IPAC) Assessment conducted by the Public Health Inspector (PHI) #139, it was noted in this report that there were many residents wandering the halls within the different units. Staff were not able to re-direct residents to their rooms or practice social distancing.

The IPAC Assessment also indicated that residents had not been identified as being on droplet/contact precautions when necessary, not all staff were aware that all residents were on droplet/contact precautions and that full personal protective equipment (PPE) was required to be worn for all direct care of residents.

Staff were not able to provide dedicated (cohort) care to only infected residents as units were a mix of positive and non positive infection cases. Staff were moving from resident to resident and unable to always provide consistent cohort care.

During the outbreak, resident #003 continued to move about the unit and was witnessed with co-residents despite being on isolation precautions.

Staff #106 was identified as working on this unit. During an interview with staff #106, Inspector #508 asked the staff if they were aware at the time that the resident was on isolation precautions. Staff #106 indicated yes, but there was nothing you could do.

b. On an identified date (day one) during the communicable disease outbreak, documentation in resident #009's record indicated that they were in close contact with resident #003.

Documentation indicated that on day seven, resident #009 was in the hallway most of the night and refused re-direction back to their room. The staff attempted to explain to the resident that they needed to remain in their room; however, this was unsuccessful.

On day eight, resident #009 was swabbed for the presence of an infection.

On day nine, it was documented that resident #009 kept in contact with other residents that were positive for infection.

On day 10, resident #009 test result came back positive for infection.

On day 11 and 12, it was documented that resident #009 was found in other resident rooms and at the nursing station.

During interview with staff #112, they also confirmed that they observed residents wandering in and out of resident's rooms during the outbreak. They also stated that they did not have enough staff to meet residents' care needs as they were so short staffed.

The only intervention included re-direction of these residents and keeping doors closed between units with signage applied to the doors.

On an identified date during the communicable disease outbreak, LTCH Inspector #535 observed these doors to be open during a tour of the unit.

It was confirmed during review of documentation including resident clinical records, IPAC assessments, during interviews with staff and through observations that residents #003 and #009 were not protected from neglect by the licensee.

2. The MLTC received a complaint related to improper assessment of resident #002.

Record review of the progress notes indicated that on a specified date, RPN #106 assessed the resident and documented that the resident had a change in health condition.

During an interview, RPN #106 verified that they attended the resident's room when they were alerted by a PSW that the resident was not looking good. The staff stated the following: It was almost time for their shift to end. They took the resident's vital signs and it was not too bad. The staff verified that they did not contact the family or the physician prior to leaving at the end of their shift. RPN #106 also stated that although they don't really do a shift report with the oncoming nurse, they explained to the nurse what was happening, they did not go back to the resident's room prior to leaving. The nurse stated that everybody in the home was sick and nobody was doing anything; they were just an agency nurse; they were the only nurse on the unit that day; and that they may have tried to call the nurse manager (RN), but usually nobody would answer the phone. When asked what the expectation was when a resident had a change of condition, the RPN stated they should have taken responsibility and called the charge nurse, the family and the physician, then follow through with the physician's orders and the family's request.

During an interview, RPN #109 verified that they worked the following shift, however they did not receive a shift report from RPN #106. The staff continued to say: most agency nurses do not know the residents well; RPN #106 did not inform them that resident #002 was experiencing a change in condition during their shift. Later during the shift a PSW alerted RPN #109 that the resident was not looking good. They attended the room, assessed the resident, took their vital signs and they thought the resident was fine. The RPN stated the resident did not look like they were in any distress.

RPN #109 stated that during the eight hours shift the resident refused their medication, meals, and fluids; and usually when the resident refuses to eat, they would drink the supplement ordered by the registered dietitian (RD). The RPN acknowledged that during the shift, the resident refused the supplement, and they returned to the room multiple times to encourage the resident to drink, but they kept refusing. When asked if they were concerned that the resident was lethargic,

the staff answered no, because over the past week the resident was usually sleepy. According to the RPN, the same situation happened one week prior, and the DOC called the family at that time and things were fine. Therefore, this time they did not call the family or the physician since the same situation was happening again. The registered staff also confirmed that they did not notify the RD that the resident was refusing the supplement. The staff acknowledged that at the end of their shift, they reported to the oncoming nurse that the resident refused their medication, food and fluids during the shift, and that they had experienced some change in condition during the previous shift, therefore please monitor the resident.

The registered staff who worked the next shift, was not available for an interview during this inspection; however, there was no documentation in the progress notes related to this resident's condition during the shift.

The next day, RPN #106 documented in the progress notes the resident was experiencing a change in condition. The physician was notified and a diagnostic test was ordered. RPN #106 documented in the progress notes: Phone call received from resident's power of attorney (POA). Requested that resident be transferred to the hospital. Will ask the oncoming shift to follow up. During the interview, RPN #106 verified the information as documented above.

During an interview, RPN #107 acknowledged that they received a report from RPN #106. Towards the end of their shift, RPN #107 documented that the resident was experiencing a significant change in condition and called POA and informed about the resident. The POA wanted the resident transferred to hospital, so 911 was called and the resident was transferred to the hospital.

During the interview, RPN #107 acknowledged their documentation as noted above. The RPN recalled that at the beginning of their shift, RPN #106 reported that two residents needed to be transferred to hospital. RPN #107 recalled that they assessed resident #002, completed their vital signs, called the substitute decision-maker (SDM) for permission to transfer the resident, called 911 and sent resident #002 out to hospital shortly after they started their shift. RPN #107 stated that during the shift report, RPN #106 informed them that they could not send the resident to hospital because they were from the agency.

Record review of the staff schedule and an email from Scheduling Clerk #149 verified that there was no nurse manager/registered nurse working in the building

when the resident was transferred to hospital.

During an interview, ED #101 verified that based on the assessment of the resident and the resident's required level of care - full code status, RPN #106 should have called the family and the physician, and transferred the resident to the hospital. The ED verified that a full chart review was completed and the RPN was given discipline as a result of their investigation. The ED acknowledged that the RPN's pattern of inaction was consistent with the home's definition of neglect. [s. 19. (1)]

3. The MLTC received a complaint related to care concerns regarding resident #006.

Record review of the progress notes indicated that resident #006 showed identified symptoms of infection and was treated with an identified treatment. Record review of the progress notes indicated that a diagnostic test was indicated but was not collected and sent to the Public Health Lab until three days after onset of symptoms by NM #138. The physician and SDM were not notified of the symptoms until three days after onset at which time the on-call physician ordered several diagnostic tests.

During an interview, RPN #116 stated that they could not recall if they reported the resident's symptoms to the NM, however, they did not notify the physician or the family at that time since they administered a treatment for the symptom. The nurse documented an unknown response when the medication was administered. There was no documentation in the progress notes to indicate resident's change in condition was reported to the nurse manager, the family or the physician.

During an interview, NM #138 verified that they collected and sent the swab as documented. They also verified that when a resident had the identified symptoms, the RPN should report it to the NM in charge of the building, a specific diagnostic test should be collected and sent to Public Health, and the resident appropriately isolated immediately.

A review of the progress notes and the resident paper chart showed no results were available for the diagnostic tests which were ordered by the on-call physician. ED #101 verified that the home was unable to locate both test results. The SDM requested and the resident was transferred to the hospital for treatment five days after the symptom onset.

During an interview, ED #101 verified that if a resident was exhibiting a symptom of an identified infection, they should have been swabbed the day they started displaying the symptom. The ED acknowledged that there were also gaps in care and service related to the collection of swabs. The gap was that part of the home's initial action plan specified that only the infection prevention and control (IPAC) lead would collect swabs, and when that staff was off work for an extended period, and the other nurse managers required training related to how to collect the swabs. The ED acknowledged the pattern of inaction described above fits the definition of incompetent resident care and neglect of resident #006. [s. 19. (1)]

4. The MLTC received a complaint related to care concerns and protocols not being followed regarding resident #014.

Record review of resident #014's progress notes indicated the following on an identified date (day one), the resident tested positive for an infection; registered staff identified reduced food and fluid intake, registered staff continued to administer the resident's prescribed which was a diuretic (water pill) despite the resident's poor fluid intake, until the medication was discontinued by the physician on day six. On that date, the RD and the primary care physician were alerted to the resident's status after the SDM sent an email to ED #100 outlining their concerns.

Physicians #129 and #131 ordered identified interventions in response to the SDM's documented concerns and their follow up assessments of the resident. Record review indicated the resident passed away in the home on day 11.

A) As indicated in the collaboration findings under s. 6 (4) (a), during separate interviews, RPNs #109, #113 and #124 verified that they did not send a referral to the home's RD when the resident was noted to have reduced food and fluid intake over a number of days to one week.

B) During an interview, RPN #124 verified that they administered a specific diuretic medication to the resident during the same period when the resident was refusing food and fluids. The RPN verified that they administered the medication to the resident, as was evident by their signature on the resident's eMAR. The RPN acknowledged that diuretic medications can cause the resident to pass more urine, and that if the resident had reduced fluid intake that could promote an

identified condition. The staff also stated that the registered staff who worked the night shift was to monitor residents' fluid intake and place them on hydration monitoring if the resident's intake was less than adequate, but that might not have happened given the limited staffing at that time.

C) RPN #124 also acknowledged that one of the side effects of taking a diuretic or water pill could be low electrolyte level. However, the RPN was not able to accurately state what interventions were used by the home to treat the resident's low blood electrolyte level. The laboratory document was date-stamped as received on a specific date; however, the physician signed and dated the document four days later, after the resident passed away. ED #102 verified that there was no order written in the resident's chart to support treatment of their low electrolyte level.

D) During an interview, RPN #113 and #137 both verified that because the resident was refusing oral intakes, the route of medication administration was changed. Both RPNs documentation on the resident's eMAR and in their progress notes indicated that for four days, the specified medication was not administered because the home did not have the medication in stock nor did they have a supply of sterile water to reconstitute the drug for injection. As a result, the resident missed four out of the first five doses of the medication. ED #101 verified that there was no incident reports completed by registered staff related to those missing doses of medications.

During separate interviews, RPN #124 and ED #101 acknowledged that there was a pattern of inaction by registered staff on the unit as documented above. RPN #124 stated that because of the pattern of inaction shown above it would be considered neglect. The ED also verified that this pattern of inaction by registered staff constituted neglect.

Therefore, the home failed to ensure residents #002, #003, #006, #009 and #014 were protected from neglect by the licensee or staff in the home.

***Additional Required Actions:***

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

**(A4)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 003**

***DR # 001 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services**

**Specifically failed to comply with the following:**

**s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).**

**s. 31. (3) The staffing plan must,**
**(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).**
**(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).**
**(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).**
**(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).**
**(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services program.

Complaints were reported to the MLTC related to staffing shortages, outbreak management, lack of personal protective equipment (PPE) for staff and care requirements of residents not being met.

An identified outbreak was declared in the home on a specified date. Complainants were concerned about the lack of nursing staff resulting in residents not receiving the care they required.

During the course of this inspection, it was identified that the home was experiencing a shortage of nursing staff and the home had hired over 70 new staff through various agencies.

The LTCH Inspectors requested a copy of the home's most recent staffing plan on June 4 and again on June 8, 2020. This was not provided to the LTCH Inspectors until June 11, 2020.

After review of the staffing plan, it was identified that the plan was in draft form and had not been finalized. During the outbreak, residents were isolated to their rooms and many required assistance with their meals and had additional care requirements. The staffing plan that was provided during this inspection did not include what actions would be taken to ensure the care requirements of the residents were met.

The LTCH Inspector confirmed with the Interim DOC that the home did not have a final or formalized staffing plan for the nursing and personal support services programs at the time of this inspection. [s. 31. (2)]

2. The licensee has failed to ensure the home's staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Record review of the home's Staffing Plan in draft and the Nursing Daily Schedules indicated that the level of staffing was below adequate numbers and staff mix to support residents' assessed care and safety needs during a specific period of time.

A review of the Nursing Daily Schedules for that same period indicated there were direct care staffing shortages in the home daily. The number of direct care staff members available to provide safe and competent assessment and care of residents, as well as the appropriate staffing mix that was consistent with residents' assessed care and safety needs were less than indicated in the draft staffing plan during normal times. The Inspector also noted that the original Nursing Daily Schedule for a specified date was missing and unavailable for review during the inspection as verified by the home's Scheduling Clerk #149.

During separate interviews, RPNs #105, #106, #109, #113 and #124 verified a significant staffing shortage in the home during that stated period. RPN #106 who was new to the home stated that during that period, they never worked with a full complement of staff on the various units which they were assigned. The staff stated that sometimes they would call the nurse manager to request support and they were told that they do not have any more staff so do the best you can. The

staff recalled coming in to work the day shift after a night shift when only one PSW had worked on the unit. The RPN described significant care concerns.

During separate interviews, NM #103 and #127 acknowledged the staffing shortage was of concern; and described a significant staffing shortage on an identified week-end. NM #103 stated that staffing levels were ok for a while after the outbreak was declared, but after a specified date it became an increasing challenge to staff the units. They stated the home redeployed all nurse managers to work on the units as staff nurses, and that the management team was in touch with their human resources staffing partners at the corporate office. The NM verified that they never used agency staff before, but they started hiring and using agency staff. The nurse manager recalled one shift when they worked on the unit with one PSW, and described the experience as challenging since residents were drowsy and there were challenges related to medication administration and feeding residents in their rooms, while trying to support all other registered staff in the building as the only registered nurse.

During an interview, NP #115 stated that while working remotely to complete residents' assessments, it was a challenge to get a hold of staff on the units to discuss how residents were looking and doing so that the information could be reported to their families. The NP stated while they were onsite assessing residents' in the home, nurses were on the unit and providing care as best as they could while working with all that they had because they were short staff and were not allowed to leave their units. The NP stated that if the staff needed additional supplies, they had to call the resource nurse to locate and bring the supplies to the floor.

During an interview, Physician #129 acknowledged the staffing shortage was an issue since staff were calling in sick, not showing up to work their shift or were in self-isolation as a result of an identified infection. The physician also acknowledged that during the outbreak the home required an increase in staffing complement to manage the situation. The physician verified that on an identified date, several residents were transferred to acute care hospitals in the surrounding area following assessments completed by William Osler's medical and nursing teams because "we were over our heads" - the home was not able to provide residents with the level of care they required due to a lack of registered nursing staff and PSWs. The physician also acknowledged that most of those residents transferred to hospital were not eating and drinking, and that they were identified as some of the sickest residents in the home.

During an interview, William Osler Director (WOD) #104, stated that the home's management team attended a virtual webcast meeting on May 4, 2020, during which support was offered to the LTC home. The WOD verified that the situation in the home was escalated by one of their own staff members who had visited to support the home and identified and reported staffing and supply shortage, as well as infection prevention and control and care concerns. WOD #104 stated that the home did not reach out to their community partners for support. However, once they were alerted about the situation in the home, the hospital sent a team of physicians and NPs to the home to assess and support residents care needs and update their families. WOD #104 verified that on June 4, 2020, the MLTC announced a voluntary management order for William Osler Hospital to assume management of the home to develop a management and recovery plan for the next 90 days. After which, they would implement a plan to transition the home back to the management team and the licensee. They also verified that the Canadian Armed Forces were onsite to augment the staffing and support resident care in the home. The WOD verified that they created a 'prototype' or an expanded Daily Nursing Staff Schedule which analyzed the daily schedule to clearly identify the following information: unit name, shift, unit census, RNs on duty, RN to resident ratio, RPNs on duty, RPN to resident ratio, PSWs on duty, PSW to resident ratio, number of sick RN/RPNs and No Show, number of sick PSWs and No Show. As per the WOD, this was the first time they were able to accurately capture the staff to resident ratios and identify scheduling issues such as which unit was short staff or required more staff because of an increase in infection positive residents, sick calls, no-show, novice versus expert staff on the unit; which unit had a short shift staff working therefore adjustments and transfer of staff required when that staff leave the unit, etc. Identification of these variables would affect the care and support residents required on the units and therefore, the number and mix of staffing required.

During an interview, the home's DOC verified that they were collaborating with the licensee to work on a staffing plan for potential staffing losses towards the end of an identified month. The DOC stated that there was a corporate memo with directions that staff bring a change of clothing to change before leaving the home. That was around the time when staffing levels started to drop, with staff citing child care support issues. That information was shared with their head office at the management meeting. The DOC also verified the critical staffing shortage experienced by the home during an identified week-end; and that they heard from staff that some of them had to work alone with one PSW on some units. The DOC

described times when nurse manager, the DOC and ED had to step in and provide direct resident care. The DOC stated that they usually took care of the scheduling along with the scheduling team, and acknowledged that the previous schedule did not identify staffing 'no shows', short shifts and number of residents current on each unit; therefore, did not support movement and re-assignment of staff to units which were short staff, or more acute based on real time numbers. They acknowledged that since WOD#104 developed a prototype staff schedule, the team was now taking into account the number of staff available to work each shift, the census on each unit, resident acuity on each home unit, and continuity of care provided by consistent staff on each home unit.

Therefore, the home failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs. [s. 31. (3)]

***Additional Required Actions:***

**CO # - 004, 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 009,004**

***DR # 003 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A complaint was reported to the MLTC, related to staffing shortages, outbreak management, lack of personal protective equipment (PPE) for staff and care requirements of residents not being met.

Documentation indicated that on a specified date, resident #003 had decreased food intake and was sleepy. The RD completed an assessment, interventions were implemented to address the requirement for an increase in calories and fluids.

NP #115 identified that the residents' intake for food and fluid continued to decline. A specific treatment was ordered for five days. Progress notes indicated that the resident refused the treatment.

The following evening, RPN #111 attempted to start the specified treatment as ordered; however, could not find supplies on their unit. They indicated during interview that there were no specific equipment required for the treatment available. It was documented in the progress notes on the resident's electronic health record, that no supplies were available.

During interview with NP #115, they indicated that they were alerted to the issue of staff not having the equipment to provide this treatment and brought forth this concern to the ED.

During interview with the DOC #102, they indicated that they had supplies on the main floor and the RPN staff should have called the Nurse Manager to access these supplies.

Due to the lack of orientation staff #111 was unaware of this process.

During a discussion with Interim ED #116, they agreed that this process especially during the outbreak was not the best process.

After this was identified and after discussion with the DOC #102, the Canadian Armed Forces (CAF) report dated June 21, 2020, with a review period from June

14 to June 20, 2020, also identified that the home did not have the equipment required to administer the specified treatment.

WOD #104 was able to arrange to borrow these supplies from the local hospital.

It was confirmed through review of the resident's clinical record, review of the CAF report and interview with RPN #111 that supplies were not readily available to meet the nursing and personal care needs of the residents. [s. 44.]

***Additional Required Actions:***

**CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 005**

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**WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every registered nursing staff (Registered Practical Nurse) had the appropriate current certificate of registration with the College of Nurses of Ontario.

During the course of the inspection, the Long Term Care Homes (LTCH) Inspectors received a list of recently hired staff whom were hired through various staffing agencies. The staff consisted of registered and non-registered nursing staff.

It was identified during review of the registered staffing credentials that RPN #113, who had been hired through the agency was not entitled to practice according to the College of Nurses of Ontario (CNO); however, that staff had worked as an RPN in the home for two weeks.

RPN #113 was identified in WN #3 related to neglect of resident #014 resulting in actual harm/risk to the resident and WN #7 related to not reporting of a medication incident. Please see WN #3 and #7 for further details.

The LTCH Inspector requested that the managers of the home follow up when this was identified and also confirmed that the RPN was not scheduled to work at the home to ensure the safety of residents. On June 19, 2020, ED #101 confirmed with Inspector #508 that the agency did not do the appropriate screening and the home also did not check their registration with the CNO to ensure they were entitled to practice prior to them working in the home. [s. 46.]

***Additional Required Actions:***

**CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions**

**Specifically failed to comply with the following:**

**s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,**
**(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).**
**(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to resident #014's SDM, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug and the pharmacy service provider.

A) Record review of the resident's eMAR and the Digital Prescriber's orders form indicated that resident #014 was ordered a medication for ten days. The resident's eMAR indicated the medication was not administered and was left blank with no signature or code to explain why the medication was not administered for five days as supplies were not available. Therefore, the resident missed four out of the first five doses of the medications ordered by the physician to support their treatment. On August 12, 2020, an email was received by Inspector #535 from IDOC #140 verifying that incident reports were not complete for the above medication incidents until recently; and the physician and resident's SDM were not notified.

B) Record review of the resident's food and fluid intake sheets indicated that resident #014 was eating and drinking poorly. A review of the resident's eMAR indicated that registered staff continued to administer a diuretic medication (water pill). In an interview, ED #101 acknowledged that the nursing staff should have notified the physician to hold the medication based on the resident's poor food and fluid intake. Record review indicated a medication incident report was not complete, and the physician and family were not notified.

C) Record review of resident #014's eMAR indicated that RPN #113 administered a pain medication to the resident on an identified date. During an interview, physician #131 stated that they had given a telephone order for a specific pain medication; however the registered staff wrote an incorrect medication. During an interview, NM #138 and DOC #102 verified that the amount of the incorrect medication administered by RPN #113 was more than they had seen administered to a resident in the home. DOC #102 further stated that there should have been an incident report completed related to the amount of the incorrect medication administered. Furthermore, the DOC stated that there should have been a follow up investigation to see if the error was related to a nurse transcription error or an error related to the physician's order. Record review indicated that a medication incident report was not completed, and the physician and family were not notified that of the medication incident. The physician discontinued the incorrect order the same date the order was written.

Therefore, the home failed to ensure the medication incident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to resident #014's SDM, the Director of Nursing and Personal Care and the Medical Director and the pharmacy service provider. [s. 135. (1)]

***Additional Required Actions:***

**CO # - 007 will be served on the licensee. Refer to the “Order(s) of the Inspector”.**

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 007**

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**WN #8: 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. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).**

**s. 229. (5) The licensee shall ensure that on every shift,**
**(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 229 (5).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

An identified communicable outbreak was declared at the home by public health. Complaints were received at the MLTC related to the outbreak management at the home.

During an identified time period, several Infection Prevention and Control (IPAC) assessments were conducted in the home by William Osler Hospital and York Regional Public Health and some of the home's management staff.

A review of the IPAC Assessment report, indicated that staff were not using PPEs as required and were not practicing social distancing. The assessment indicated that approximately 40%-50% of staff were wearing an identified mask, and that only one mask was provided for staff to be worn during their shift. Some were bringing their own and others were offered from the facility. The identified masks were not being changed after direct contact with residents positive for infection and negative residents and unclean identified masks were being re-used by staff after their breaks.

Some lunch rooms did not have masks for the staff to put on in the lunch room after having a meal.

Staff had to go into the hallway without a mask to find one.

It was also noted in this report that there were many residents wandering the halls within the different units. Staff were not able to re-direct residents to their rooms

or practice social distancing.

Residents had not been identified as being on droplet/contact precautions when necessary. Not all staff were aware that all residents were on droplet/contact precautions and that full PPE was required to be worn for all direct care.

Staff were not able to cohort care to only positive residents as units were a mixture of both positive and negative infection cases. Staff were moving from resident to resident and unable to always provide continuous cohort care.

It was identified during this report that staff required education regarding the proper use of PPE, including donning and doffing.

Staff who were recently hired indicated during interviews that they received little to no orientation prior to working at the home.

After the outbreak was declared, residents who were positive for a specified infection were cohorted to a specific unit.

The unit was separated by doors and caution signage was applied; however, on June 2, 2020, Inspector #535 toured the facility and identified that although the doors were to be kept closed, they were observed to be open.

NP #115 was working onsite at the home and identified that there were not enough hand sanitizers for staff and that the nurse administering medications had an empty bottle of hand sanitizer. PSW staff advised the NP that many of the hand sanitizers were empty or the dispensers were not working. They also observed that there were not enough garbage bins to dispose of used PPEs.

On May 31, 2020, an order was issued to the home and the licensee by York Region Public Health.

In a section of the order, it identified that they had received documentation that the home had inadequate and/or insufficient infection prevention and control (IPAC) knowledge and processes to protect resident needs. The home required assistance from York Region Public Health and the Central West Local Health Integrated Network (CW-LHIN) to attend the home and provide IPAC expertise and education for staff, to ensure residents received the necessary care and treatment required to contain the spread of infection during the outbreak.

On June 2, 2020, IPAC Extender #128 who was working in the home identified ta room with a resident on droplet/contact precaution did not have a PPE caddie in place; and on one unit, a fan was observed in a resident's room.

During an interview, staff #112 who had been recently hired stated that they only worked a couple of shifts in the home and that they would not be returning to work in the home again due to the lack of orientation and PPE availability to front line staff.

They indicated that there were only two PPE caddies set up on the unit; however, majority of the residents living on the unit were positive for a specified infection. They also stated that surgical masks were not made readily available. And, they were told to wear one surgical mask per shift; and if the mask was soiled, they could get another mask but had to request it from the Nurse Manager (RN) on duty.

During one of the shifts, the staff indicated their surgical mask broke and they had to wait approximately 30 minutes to get another mask as the RPN was busy administering medications to residents.

The Canadian Armed Forces (CAF) team who were deployed to the home also identified IPAC issues in the home. They reported staff not complying with screening policies when entering the facility. PSWs were observed providing care to residents without gowns, and a snack cart was delivered to a positive unit mistakenly, then sent to a negative unit in a report dated June 28, 2020.

It was confirmed through review of documentation, observations and interviews that staff did not participate in the implementation of the home's infection prevention and control program. [s. 229. (4)]

2. On May 31, 2020, the Medical Officer of Health from the Regional Municipality of York issued an order under Section 29.2 (1) of the Health Protection and Promotion Act, to the home to take the following action related to active surveillance:

Ensure staff are trained on the appropriate use of personal protective equipment and tools and follow directions on the use of PPE as provided by York Region Public Health, William Osler Health System, Public Health Ontario, and the

Central West Local Health Integrated Network (CW-LHIN).

During three separate tours conducted in the home on June 2, 3, and 7, 2020, Inspector #535 observed multiple concerns on all home units related to infection prevention and control as follows:

a. Resident #018 whom staff identified as positive for a specified infection was standing at the nursing station, wandering the hallway and coughing intermittently. PSW was informed.
b. Activation staff #130 voiced uncertainty of what personal protective equipment (PPE) to wear when going into residents' rooms to serve the meals, asking if they should wear full PPE or just a mask and face shield.
c. Observed second wandering resident using a walker in the hallway beyond the locked doors.
d. Observed garbage containers overflowing onto the floor with used PPEs such as gowns and gloves. Housekeeping staff was informed.
e. Observed physician #131 who assessed a resident and was searching for a working hand sanitizer dispenser to clean their hands. The physician entered three residents' rooms and containers were empty. They finally found a hand sanitizer with solution down the hall and around the corner.
f. Observed three residents sitting beside each other in a TV lounge with no social distancing between them. Inspector was informed by staff that they were wandering residents. Registered staff had informed the inspector upon entry to the unit that there were five or six residents who were negative still residing on the positive unit at that time.
g. Observed resident #013 wandering in and out of other residents' rooms throughout the unit, touching side rails, sitting in other resident's room in the chair and on their bed. Also observed that the double doors separating the unit were left opened.
h. Observed PSW #132 walking around on the unit with two supermarket plastic bags tied on their feet to use as shoes cover. When asked why, the staff stated that booties were not available to cover their shoes while working on the unit.
i. Observed that home units did not have enough hampers for staff to discard PPEs upon removal when exiting residents' rooms.
j. While checking random dispensers throughout the home, observed that hand sanitizers were empty.
k. Observed one staff wearing two yellow cloth gowns and full PPE inside the nursing station. When asked why they were wearing full PPE in the nurses station since it was designated a clean area, Activation Staff #133 stated that they were

not aware that they could not wear their gown in the nurses' station because they were away from the home, and had just returned back to work today. The staff was wearing two gowns, two surgical face masks and a face shield.
l. Observed multiple residents wandering in the hallways on two units.

While conducting this on-site inspection, Inspector #535 was provide with three different IPAC practice change of instructions related to what PPE to wear when entering affected resident care units.

During an interview, IPAC Extender (IPACE) #128 stated that they were from the CW-LHIN. And, they would be on-site daily for the next few weeks to support the home by conducting hand hygiene audits and infection prevention and control education support to staff, in small groups and one on one during walkabouts on various residents home areas. IPACE #128 stated that they frequently had to remind staff of the appropriate use of PPE, but that was a part of their role in the home.

During an interview, RPN #105 stated that there was a time when they would get only one mask for the day sometime around the beginning of May 2020. They would get the mask at the entrance during screening; and they would have to wear the mask for the entire shift; if they needed more PPE, they would have to call the nurse manager on duty. The staff stated they did not have gowns at that time, and they had some gloves, but they had to minimize there use so that they would not run out. The staff stated that the large gloves were going very fast; and some staff were vocal about the lack of PPE supplies that were made available to direct care staff on the units.

During an interview, IPAC Lead #103 stated that after the previous DOC left the home in March 2020, they co-shared the IPAC Lead role with the current DOC #102. IPAC Lead #103 verified that the home was declared in outbreak and that two wandering residents on two floors initially tested positive for infection. The IPAC Lead stated that ten days later, 22 residents tested positive and now there was a mixture of positive and negative residents on all units which posed a challenging issue with wandering residents living on each home area. The IPAC Lead stated that with directions from their corporate office, wandering residents were moved to the rooms before the closing fire doors; however those residents would remove yellow wander strips from across room entrances, and whenever the fire doors were left open, they would wander back and forth in the hallways and into other residents' rooms. The IPAC Lead stated that the home tried to

recruit students to support one to one monitoring, but they would come one day, then not show up for next shift. The ADOC stated that the team talked about housing all wandering residents on one unit, however they were concerned about possible effects of moving them to a new environment which might escalate their responsive behaviors. Therefore, on one unit, Activation Staff #133 was scheduled to keep wandering residents engaged. They also tried to create an illusion of a black hole by putting black strips of tape on the floor in front of their room doors and in front of the double fire doors. They also used anti-psychotic medication to control their wandering behaviors, however these strategies worked sometimes but they were not fully effective.

During an interview, Supporting DOC #117 (SDOC) stated that they encountered some conflicting IPAC information and practices when they entered the home. The information was mainly related to inconsistencies in the use of infection control signage. For example, the use of PPE when donning and doffing; and displaying of droplet/contact isolation signage on residents' doors - the home was advised to put droplet/contact signs up on all resident doors in the home, and to display donning and doffing signs on all resident's door. According to the SDOC, they were told this by the York Region Public Health team. The rationale provided was because the whole home was in outbreak, therefore all residents should have the sign up whether they were positive or negative for infection. However, SDOC #117 thought that if they were really trying to be consistent and sure that staff comprehended the IPAC education being provided, they should know why they were performing that task, and that information was not provided to them. Therefore, the home was posting signs for all positive and negative residents' room doors. So, the only thing that would distinguish positive and negative residents on the units were the addition of a specified marking to signify positive residents.

The SDOC further stated that staff understood the importance of donning and doffing of PPE; however they were provided with multiple change in directions related to what to wear when providing direct care to residents, short visits to a resident's room, walking in the hallway and working in the nurses station. The SDOC stated that during that time, there was a lot of confusion amongst the staff. And, even they were confused related to the proper use of PPE since many different instructions were discussed and implemented in terms of PPE use of goggles, face shields, mask and gloves.

During an interview, DOC #102 stated the following: after the outbreak was

declared, residents condition were stable; physicians saw residents who staff identified as high risk and the ED and DOC rounded every day to speak with staff. Then on the designated "infection unit" staff members started saying they were going to leave and not return to work because of the high risk of exposure or transmission to their families at home. But that soon settled when a staff member was hired to monitor and support wandering residents. The DOC stated that everything changed when a Public Health Investigator (PHI) #139 visited the home unannounced. They conducted a walkabout and immediately started correcting staff members infection control practices by telling them that they were not doing the right things, and that they were doing opposite to what they should have been doing related to PPE and infection prevention and control practices. Team members went from knowing what mask and other PPEs to wear, to being completely confused. The DOC stated that PHI #139 told staff to change their mask after provision of care to or contact with each resident; however, by that time, the home had already cohorted positive residents therefore that did not need to happen, and it was not in alignment with the homes's practice. There was also no agreement regarding the use of face shields. PHI #139 stated that when staff leave the resident's room, they should remove and wipe the face shield, then wait for one minute before putting it back on to enter another resident's room. The DOC stated that was taking time away from resident care and it was causing self-contamination. The DOC stated that there was confusion and conflict related to the IPAC information and education received in the home prior to PHI #139's visit. And, the home did not receive an IPAC report from PHI #139 related to that visit.

According to the DOC, the confusion did not help and staff members started wearing PPEs inappropriately. The DOC stated that they sent an email to their clinical support staff because York Region Public Health (YRPH) instructions appeared to be different from the home's infection prevention and control teaching, which was in alignment with Peel Regional, Toronto and Muskoka Public Health IPAC information. The DOC also stated that their corporate office IPAC leads provided virtual and onsite IPAC re-education for all staff members to rebuild trust and clear up any miscommunication. However, staff members were upset and voiced that they were scared because they came in to work to do their best but that they were being put at risk. The DOC stated that was when their positive resident cases started to increase.

DOC #102 verified that there was inappropriate use of PPE by staff members and the inability to contain wandering residents on the resident care units, contributed to the steep climb of positive resident cases, and the situation was a continuous

challenge. They verified that they were rationing face masks for staff in the home since the ministry asked long term care homes to keep a record of their daily use, and they were being conservative. They also confirmed that they were in the middle of the home's outbreak when PPE supplies were made accessible to staff on the units, however mask and gloves were always made available in the resident care units. The DOC further confirmed that as per their corporate office directive, staff were provided with one mask but if the mask was soiled or broken, they could get a new mask by calling and requesting one from the nurse manager on duty.

Therefore, the home failed to ensure that staff participated in the implementation of the infection prevention and control program. [s. 229. (4)]

3. The licensee has failed to ensure staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice.

Record review of the home's IPAC surveillance records and the York Region Respiratory Outbreak Line Listing indicated that the document to be completed by registered staff on each resident care unit was sometimes incomplete, and did not consistently capture residents' symptoms including their temperature.

During an interview, Support DOC (SDOC) #117 stated that they started working in the home on June 2, 2020, to support IPAC surveillance and accurate line listing of residents. They were responsible for sending the line list to York Regional Public Health (YRPH) daily. When they arrived and reviewed the home's infection surveillance records, it was difficult to figure out how to move forward because of the lack of consistent information recorded on the line listing document. They created a new excel document for ease of use by staff. The SDOC stated that they posted the updated spreadsheet document daily on each resident care unit so that staff could access that information. The posting of residents line listing on all units was not happening prior to their arrival in the home.

According to the SDOC, to promote efficiency, they informed the team to stop using the internal surveillance record and to only use the York Region Respiratory Outbreak Line-Listing document to track symptoms in infection positive residents so that it could be submitted to public health when completed instead of having to transfer the information.

On May 31, 2020, the Medical Officer of Health from the Regional Municipality of York issued an order under Section 29.2 (1) of the Health Protection and Promotion Act, to the home to take the following action related to active surveillance:
Provide accurate and timely information requested by York Regional Public Health, William Osler Health System, Public Health Ontario, and the Central LHIN West Local Health Integrated Network regarding any and all aspects if the outbreak in the institution. This includes but is not limited to providing York Regional Public Health no later than 10 a.m. each day, the name and requested details for staff and residents symptomatic for infection and the names and requested details for asymptomatic residents and staff who have tested positive for infection.

Therefore, the home has failed to ensure staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice. [s. 229. (5) (a)]

***Additional Required Actions:***

**CO # - 008, 010 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A2)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 008,010**

***DR # 002 – The above written notification is also being referred to the Director for further action by the Director.***

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**WN #9: 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. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,**
**(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).**
**(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).**

**s. 6. (5) The licensee shall ensure that the resident, the resident's substitute decision-maker, if any, and any other persons designated by the resident or substitute decision-maker are given an opportunity to participate fully in the development and implementation of the resident's plan of care. 2007, c. 8, s. 6 (5).**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of residents #002, 004, 007 and 014 so that their assessments were integrated, consistent with and complemented each other.

The Ministry of Long-Term Care (MLTC) received a complaint related to assessment of resident #002.

Record review of resident #002's progress notes indicated that the home's RD #108 assessed resident #002 remotely, and documented was not likely not meeting energy and fluid needs and refer back to RD if declined in order to provide a substitute.

Record review of the progress notes and food and fluid records indicated that the resident continued to refuse medication, meals and fluids.

During separate interviews, RPN #105, #106 and #109 verified that resident #002 continued to refuse meals, medication and fluids after the RD's assessment and recommendations; and all verified that they did not call or refer the resident back to the RD, as documented by the RD above.

During an interview, the home ED #101 acknowledged that registered staff should have at least notified the RD to alert them that the resident's intake remained poor, so that the RD could reassess the resident and provide recommendations. [s. 6. (4) (a)]

2. The MLTC received a complaint related to care concerns identified regarding resident #004.

Record review of resident #004's progress notes indicated that the home's RD #108 assessed resident #004 remotely, as a result of an electronic referral indicating the resident was refusing to eat. They documented the resident was likely not meeting energy, protein and fluid needs recently. The RD recommended a specified nutrition supplement verbally to the charge nurse.

Record review of the progress notes and the daily food and fluid records indicated that the resident continued to refuse meals and fluids, and that registered staff were inconsistently documenting that the resident was having reduced food/fluid intake.

During an interview, RD #108 stated the resident had an infection increasing their fluid needs. The RD also verified that if the resident had changes made to their diet texture and supplements ordered, the nurse should send a referral to the RD and the kitchen should also be notified using a diet order form.

During separate interviews, RPN #105, #106 and #107 verified that resident #002 continued to have poor intake of food and fluids after the RD's assessment and recommendations; and all verified that they did not notify or send another referral to the RD related to the resident's intake status.

During an interview, the home ED #101 acknowledged that registered staff should have at least notified the RD to alert them that the resident's intake remained

poor, so that the RD could reassess the resident and offer other suggestions. [s. 6. (4) (a)]

3. The MLTC received a complaint related to care concerns regarding resident #007 on June 4, 2020.

Record review of resident #007's progress notes indicated the resident almost always refused to take their medication.

During separate interviews, RPNs #105 and #109 both acknowledged that the resident was not eating and drinking much in a specified month. RPN #105 further stated that the resident stayed in their room and was drowsy and sleepy. Both RPNs verified that they did not send a referral to the home's RD.

During an interview, the RD verified that they did not receive a referral related to this resident, and that the resident would not have been on their radar because the resident was listed as medium risk.

During an interview, DOC #102 stated that a RD referral should have been sent within 24 - 72 hours if the resident was not eating and drinking. The DOC agreed that an RD referral was warranted.

ED #101 acknowledged that the staff should have referred resident #007 to the RD for an assessment if the resident was not eating and drinking. [s. 6. (4) (a)]

4. The MLTC received a complaint related to care concerns and protocols not followed regarding resident #014.

Record review of the resident's daily food and fluid intake records showed that there was a significant decrease in the resident's oral intake of food and fluid.

The RD verified that they did not receive a call or referral from the nursing team on the units when the resident had a decrease in oral intake of food and fluid; however they received an email from ED #100 on a specified date which stated family concerns regarding the resident's poor intake of food and fluids.

Based on the information in the email, while working remotely, the resident's chart was reviewed and the following assessment was documented by the RD: Noted resident was not meeting their nutritional needs. RD recommendations: start a

specified supplement and to start a specific treatment if SDM agrees.

RD was unable to contact the charge nurse on the unit, therefore, they emailed recommendations to ED #100, IDOC #102, and ADOC #103. That same afternoon, a verbal order was also provided to the charge nurse on the unit. The RD verified during the interview that the supplement was ordered to support the resident's refusal of meals; and the specified treatment was ordered because of poor fluid intake.

During separate interviews, RPNs #109, #113 and #124 acknowledged that the resident was not eating and drinking during a specific time period. RPN #124 further stated that the physician ordered a specified treatment for the resident, but the resident was refused the treatment more than once. When asked if they had completed a referral to the RD, the staff checked the computer and stated they did not locate a referral therefore, they may not have sent the referral. The staff acknowledged that the resident should have been referred related to their decreased intake of food and fluid. RPN #109 verified that they did not refer the resident for a dietary assessment.

During an interview, DOC #102 stated that a RD referral should have been sent within 24 - 72 hours if the resident was not eating and drinking. The DOC agreed that an RD referral was warranted.

ED #101 acknowledged that the registered staff should have referred resident #014 to the RD for an assessment if the resident had poor or reduced intake as identified by the various staff on the unit.

Therefore, the home failed to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of residents #002, #004, #007 and #014 so that their assessments were integrated, consistent with and complemented each other. [s. 6. (4) (a)]

5. The licensee has failed to ensure resident #002 and #014's substitute decision-makers (SDMs) were provided the opportunity to participate fully in the development and implementation of their plan of care.

The MLTC received a complaint related to assessment of resident #002.

Record review of the PCC progress notes indicated that on an identified date,

RPN #106 assessed the resident and documented that the resident was experiencing a change of condition.

During an interview, RPN #106 stated that they were notified by a PSW that resident #002 was not looking well. The RPN assessed the resident and confirmed that they documented the information above. They also verified that they did not notify the resident's SDM or the physician related to the result of their assessment of the resident.

During an interview, Nurse Manager (NM) #127 verified that the resident's SDM should have been notified of the resident's change in condition so that they could participate in the resident's plan of care. [s. 6. (5)]

6. The MLTC received a complaint related to care concerns and protocols not being followed regarding resident #014 on May 26, 2020.

Record review indicated that on a specific date, RPN #113 documented the resident exhibited a change of condition and the family/POA had been updated regarding the status of the resident.

During an interview, SDM #144 stated that they had documented notes which showed that they called the home and spoke with the day nurse who informed them that the resident had a change of condition. The SDM verified that they did not receive a call or any form of communication from the registered staff indicating that the resident had a change of condition the previous day.

During an interview, RPN #113 stated they could not recall if they had called and spoke to the family. However, they called and spoke with the family for certain the next day.

During an interview, NM #138 verified that the physician, NM and the family should have been notified about the resident's change in condition by the registered staff.

During separate interviews, SDMs #144 and #145 also stated they felt the home's management was not honest and transparent about what was happening related to staffing shortages and the morbidity and mortality of residents during the outbreak in the home. Therefore, the lack of communication and transparency impeded the family's rights and ability to fully participate in both residents health,

wellness and safety during the outbreak. Families expressed disappointment, helplessness, anger and frustration regarding the situation in the home and wanted to ensure their thoughts and feels were communicated.

Therefore, the home failed to ensure residents #002 and #014's SDMs were provided the opportunity to participate fully in the development and implementation of the plan of care. [s. 6. (5)]

7. The licensee has failed to ensure that resident #013's plan of care was reviewed and revised when the care set out in the plan of care was not effective, and different approaches were considered.

During the tour of the home on June 2, 2020, Inspector #535 observed resident #013 wandering up and down the hallway on their home unit, walking with and helping to push the meal service cart with PSWs while they were serving the lunch meal. They were observed walking in and out of other residents' rooms while pausing to sit on their chair/bed, and touching those other residents' personal belongings.

Record review of the progress notes indicated that resident #013 tested positive for an infection and was to be on contact/droplet precautions and remain isolated in their room.

RPN #151 documented: Pt wandered off to co-resident's room and fell asleep at the foot of their bed. Pt assisted x 3 to own room. Will continue to monitor patient safety and behavior.

During an interview, RPN # 123 verified that the resident wandered around the unit and into other residents' room a lot. The RPN verified that the resident was ordered a specific treatment as needed, which was sometimes effective in managing behaviours. However, the resident wandered around the unit and although staff tried to re-direct them back to their room by using their interventions, these were not effective. The resident was sometimes hard to redirect and still wandered out of their room and into other residents' rooms when staff were busy providing care to other residents.

During an interview, ADOC #103 who was also one of the IPAC Leads, verified that one of the home's challenging issues during their outbreak was wandering residents. The ADOC named examples of other residents who wandered on their

home units during the outbreak. The ADOC stated that they tried cohorting wandering residents close to the nursing station and tried to keep the fire doors closed between units, sometimes they still opened the doors and wandered in the hallways beyond those doors and entered other residents' rooms. The ADOC stated that prior to the outbreak, yellow stop strips across the doors did not work because the residents removed the strip and entered the rooms. Stop signs were also posted in their native language, but those strategies were still not effective. The ADOC agreed that a new approach was needed, however the home did not have enough staff to implement one to one monitoring for all wandering residents.

Therefore, the home failed to ensure resident #013 was reassessed and the plan of care revised because care set out in the plan of care had not been effective, different approaches were not considered in the revision of the plan of care. [s. 6. (11) (b)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff and others involved in the different aspects of care collaborated with each other in the assessment of the resident, so that their assessments are integrated, consistent with and complemented each other; that the resident's SDM was provided the opportunity to participate fully in the development and implementation of the plan of care; and that the resident's plan of care was reviewed and revised when the care set out in the plan of care was not effective, and different approaches were considered, to be implemented voluntarily.***

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**WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning**

**Specifically failed to comply with the following:**

**s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,**
**(d) includes alternative beverage choices at meals and snacks; O. Reg. 79/10, s. 71 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure the menu cycle included alternative beverage choices at meal and snacks.

Record review of email communications between ED #100 and Nutrition Manager #118 indicated that the home did not offer or serve a choice of hot beverages such as tea and coffee, to residents.

During an interview, SDM #147 informed Inspector #535 that the home was serving only cold food and beverages to residents during a specific month.

During an interview, Nutrition Manager (NM) #118 stated that they were informed of the home's Pandemic Menu which included cold food and fluids, however the home had not implemented the full menu as proposed. NM #118 further verified that residents were served hot meals as a first choice, but they were not offered and served a choice of hot beverages such as tea and coffee.

Furthermore, NM #118 confirmed that Regional Director of Marquise (RDM) #110 who was aware of the cultural importance of hot/warm beverages for those residents who preferred tea and coffee with meals, brought forward a proposal to the previous ED #100. The proposal indicated a strategy for serving individualized portions of hot beverages to residents that would mitigate potential risk.

NM #118 verified that the ED accepted the proposal to serve individualized portions of tea and coffee to resident during all meals. The NM further clarified that the menu served to residents during a specific time period, did not show that the home had not served hot beverages to residents on those dates since it was just directives discussed at their Management Meetings.

Therefore, the licensee failed to ensure the menu cycle included alternate beverage choices at meals and snacks. [s. 71. (1) (d)]

***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 the menu cycle includes alternative beverage choices at meal and snacks, to be implemented voluntarily.***

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service**

**Specifically failed to comply with the following:**

**s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:**
**5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that food service worker and other staff assisting residents with their meals were aware of residents' diets, special needs and preferences.

Observations by the Inspector during a specified meal showed PSW #140 with multiple residents' meals on a serving cart. They were pushing the cart down the hallway and stopping to serve residents' meals in their room. The meals were served in white disposable containers with no identifying labels on the containers.

During an interview, PSW #136 acknowledged that the meal containers did not have a label with residents' name, room number and meal texture. The PSW informed the Inspector that they knew the residents well and knew their meal texture since that had not changed. PSW #136 also acknowledged that it was possible for a resident to be served the wrong meal textured by not labeling each resident's meal container or tray with their name, room number and meal texture.

During an interview, the dietary staff #152 informed the Inspector that there were labels available which should be applied to each resident's meal container before serving, however some PSWs stated they already know the residents and were not applying the labels when serving the meal.

During an interview, Nutrition Manager #118 verified that all residents' meals and/or trays should be labelled with stickers supplied to the staff with the resident's name, room number and meal texture before serving them. [s. 73. (1) 5.]

***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 food service worker and other staff assisting residents with their meals are aware of residents' diets, special needs and preferences, to be implemented voluntarily.***

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care**

**Specifically failed to comply with the following:**

**s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,**
**(a) has at least one year of experience working as a registered nurse in the long-term care sector; O. Reg. 79/10, s. 213 (4).**
**(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and O. Reg. 79/10, s. 213 (4).**
**(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the Director of Nursing and Personal Care had at least one-year experience working as a registered nurse in the long-term care sector, and at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

During an interview with the home's DOC #102, they informed Inspector #535 that they started working in the long-term care home in an managerial role for approximately one year.

Therefore, the licensee failed to ensure that the Director of Care had at least one-year of experience working as a registered nurse in the long-term care sector, and at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting. [s. 213. (4)]

***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 Director of Nursing and Personal Care has at least one-year of experience working as a registered nurse in the long-term care sector, and at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting, to be implemented voluntarily.***

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**WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints**

**Specifically failed to comply with the following:**

**s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a written complaint that was received concerning the care of a resident or the operation of the home was immediately forwarded to the Director.

Complaints were reported to the MLTC related to staffing shortages, outbreak management, lack of Personal Protective Equipment (PPE) for staff and care requirements of residents not being met.

Resident #003's family member had communicated to NP #115 who was working at the home that they had a number of concerns related to the resident's care needs not being met.

This information was sent via email to the DOC #102 and ED #100 on a specified date, as the family member indicated that they had left multiple messages with the DOC; however, had not heard back from anyone at the home and attempts to reach staff on the unit were unsuccessful.

Review of this correspondence indicated that the family were concerned about resident's recent falls, treatment not provided due to availability of supplies, and the family felt the care was deficient.

They were considering transferring the resident to the hospital due to these issues.

During interview with Interim ED #116, they indicated that they followed up with the complainant; and DOC #102 confirmed that they had not forwarded the complaint to the Director. [s. 22. (1)]

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints**

**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a documented record was kept in the home that included; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions taken and any follow-up action required.

NP #115 documented in resident #003's clinical record that they had communicated with the resident's family member and they had raised concerns that the resident's care needs were not being met. This information was sent via email to the Interim DOC and the ED as the family member indicated that they had left multiple messages with the DOC; they had not heard back from anyone at the home and attempts to reach staff on the unit were unsuccessful.

Review of this correspondence indicated that these were family concerns and included a number of care concerns such as recent falls, treatment not provided due to availability of supplies, and also indicated the family felt the care was deficient.

During this inspection, the LTCH Inspectors reviewed the home's complaint log for 2020. There was no record of this complaint. LTCH Inspector #508 requested documentation regarding this complaint including the actions taken in regard to the family members concerns.

In an interview, interim ED #116 indicated that they did follow up with the family member to address their concerns verbally on two occasions; however, the actions taken, time frames for actions to be taken and the follow up action required had not been documented.

It was confirmed through documentation review and during interview with Interim ED #116 that the actions taken, time frames for actions taken and follow up action required related to concerns raised by resident #003's family had not been documented. [s. 101. (2)]

**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 233. Retention of resident records**

**Specifically failed to comply with the following:**

**s. 233. (2) A record kept under subsection (1) must be kept at the home for at least the first year after the resident is discharged from the home. O. Reg. 79/10, s. 233 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that resident #014 records were kept at the home for at least the first year after the resident was discharged from the home.

A review of the resident's paper chart indicated that the resident's Individual Narcotic Sheets were not located in the chart.

On August 12, 2020, Inspector #535 received an email from Interim DOC #140 which verified that they could not locate the resident's individual Narcotic Sheets.

Therefore, the home failed to ensure that resident #014 records were kept at the home for at least the first year after the resident was discharged from the home. [s. 233. (2)]

**Issued on this 22nd day of January, 2021 (A4)**

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

**Original report signed by the inspector.**

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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

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

## Amended Public Copy/Copie modifiée du rapport public

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by PRAVEENA SITTAMPALAM (699) - (A4) |
| **Inspection No. / No de l'inspection :** | 2020_780699_0014 (A4) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 006859-20, 008209-20, 010332-20, 010770-20, 011235-20, 012616-20, 013288-20, 015463-20 (A4) |
| **Type of Inspection / Genre d'inspection :** | Complaint |
| **Report Date(s) / Date(s) du Rapport :** | Jan 22, 2021(A4) |
| **Licensee / Titulaire de permis :** | 2063414 Ontario Limited as General Partner of 2063414 Investment LP<br>302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Woodbridge Vista Care Community<br>5400 Steeles Avenue West, Woodbridge, ON, L4L-9S1 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Kerri Judge |

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

To 2063414 Ontario Limited as General Partner of 2063414 Investment LP, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 001

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

**Order / Ordre :**

The licensee must be compliant with s. 8. (3) of the LTCHA.

Specifically, the licensee must:

-Ensure there is at least one registered nurse who is an employee of the licensee and a member of the regular nursing staff on duty and present unless there was an allowable exception to this requirement. Alternatively, if no RN is available to be in the building, an extra RPN must be scheduled to work in the home without a scheduled assignment, with an on-call RN, or DOC being available for consultation.

## 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

**Grounds / Motifs :**

1. The licensee had failed to ensure there was at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff on duty and present unless there was an allowable exception to this requirement.

Record review of the long-term care home's staffing schedule for the months of April, May, June and July 2020, indicated the home did not have a registered nurse (RN) on duty and present in the building for eights shifts. During these shifts, the scheduling clerk did not indicate that an extra RPN was scheduled to cover the role of the RN on duty.

This information was verified by the home's Scheduling Clerk #149 and ED #101 on July 30, 2020. ED #101 also added the following statements related to the Nurse Manager (NM/RN) role in the home: If an RN is working on the unit, the RN can still be the nurse in charge. Also, pre-outbreak the RN on night shift also covered the first floor and was in-charge. The times when an RN is not in the building, the process was to ensure that there was a RN or the Director of Care (DOC) available on call to support clinical decision-making and risks. There would also be a designated RPN in charge who would take the lead to support with acquiring resources as needed, contacting the RN on call, on call manager in some cases and/or DOC/ED.

Therefore, the licensee has failed to ensure at least one registered nurse who was an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times.

The severity of this issue was determined to be a level 2 as there was minimal harm/risk to the residents. The scope of the issue was a level 3 as it was related to the whole home. The home had a level 2 history as there were previous non-compliance to a different subsection. (535)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Oct 26, 2020(A2)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 002

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

**Order / Ordre :**

The licensee must be compliant with s. 15 (2) of the LTCHA.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

This plan must include, but is not limited to, when the flooring and ceiling tiles will be replaced and or repaired, cleaning of the windows, replacement of window screens, repairing of damaged walls, door frames, tub room toilet, nursing stations and any other identified areas requiring repair or replacement that were identified by the Inspector on June 17, 18 and 19, 2020.

Please submit the written plan for achieving compliance for inspection #2020_780699_0014 to Praveena Sittampalam, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by September 25, 2020. Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. The licensee has failed to ensure that furnishings and the home were maintained in a good state of repair.

i) On June 17, 18 and 19, 2020, a tour of the home was conducted and noted numerous instances of water damaged ceiling tiles throughout the home were not maintained. In some cases, the ceiling tiles were missing, badly stained, with or without water-logging or painted over with white paint. The water damaged tiles also presented an infection control risk as they are a suitable environment to support growth of mold. Damaged ceiling tiles were found on all floors as well as in the laundry room.

ii) During the tour of the home there were areas of damaged flooring throughout the home and on all floors as follows:

On the first floor, flooring was found to be damaged in one stall of the female staff change room, and in one unit corridor, flooring baseboard was loose with a large gap present. In the laundry room, flooring was badly damaged both on the "clean side" and "dirty side". In the kitchen, flooring was damaged near the walk-in fridge/freezer. Outside of an identified room, in the hallway, flooring was damaged along the centre line.

In the second floor hallway, flooring was cracked at the centre line running from the nursing station to the fire doors, as well as floor tiles broken across from the elevators.

On the third floor, it was noted in an identified room that the washroom floor covering was pushed in, representing a possible infection control risk. In the Soiled Utility room across from an identified room, baseboards were pulling away from the wall leaving gaps, representing a possible infection control risk.

On the fourth floor, in three different resident rooms, the baseboards were pushed in and noted to be an infection control risk. In Unit 4B, North Lounge wall baseboards had numerous gaps, representing an infection control risk.

iii) Dirty windows were noted on all floors in the home. In two rooms, there were cuts observed in the screens which would allow insects to enter those rooms.

iv) General un-repaired damage in residents' rooms and common areas noted as follows:

On the first floor, damaged wall was observed outside an identified room. In another room, the washroom door frame was badly chipped. The tub room toilet seat surface was rough for residents' to sit on; and the door frame protection had a chunk missing at the bottom (inside the room), and a sharp piece sticking out was an injury risk.

On the third floor, there were dents in the walls in a room, and another room only had one of two light bulbs working in the washroom. In the Soiled Utility room, the covering was peeling from the wall which was an infection control risk. There were numerous holes in the wall, and the baseboards were pulling away from the wall leaving gaps, and holes left in the wall as a result of a previously removed dispenser.

On the fourth floor, North residents' washroom, the wall covering was broken along the seam; and in the North residents' lounge, the area of walls close to the lounge was damaged, and white paint was applied but not the matching color. In the Dining room, the wall protection was peeling from the wall, and there were metal studs exposed. In the South residents' washroom, the wall was damaged and the repair was incomplete. The toilet tank cover was broken.

v) Damaged nursing stations were noted throughout the home with the wood showing where protective coverings were worn, and some areas were covered with duct tape which represented an infection control risk.

vi) The home recently hired a new Director of Environmental Services (DES), therefore an interview was conducted with ED #101 related to the Inspector's observations. ED #101 confirmed that there was no work orders entered into electronic maintenance system for completion related to repairing or replacing flooring in the past year. During an interview, DES #154 indicated that the focus right now was to deal with the outbreak; and that once the outbreak was declared over, then attention would be turned to dealing with the maintenance backlog.

The severity of this issue was determined to be a level 2 as there was minimal harm/risk to the residents. The scope of the issue was a level 3 as it was related to the whole home. The home had a level 2 history as there were previous non-compliance to a different subsection. (145)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Mar 15, 2021(A4)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**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. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

**Order / Ordre :**

The licensee must be compliant with s. 19(1)

Specifically, the licensee shall prepare, submit and implement a plan to ensure that residents are not neglected by the licensee or staff. This plan must include:

1. The development and implementation of minimum training and orientation requirements for new registered staff to be completed prior to working on the resident care units. This minimum training must include, but is not limited to the following:
-Where and how staff can access supplies;
-How to complete laboratory orders; and
-How to escalate resident and/family concerns.

2. The development and implementation of a supplementary training program to ensure all registered staff complete a resident head to toe assessment course with information to include, but not limited to, physical assessment of a resident, when to contact the physician, dietitian, nurse manager, DOC and routine vital signs to include pain and oxygen saturation levels.

3. The development and implementation of written protocols to ensure the physician, NP and dietitian are made aware of when a resident is placed on hydration monitoring status.

4. The development and implementation of written protocols to ensure registered staff on duty notify the physician or Nurse Practitioner and the Nurse Manager when a resident experiences a change in health condition and/or consistently refuses to take their prescribed medications, as warranted.

5. The development and implementation of a written procedure to ensure registered staff document and keep a permanent record of the date and time physicians are contacted, the reason for the call, orders, outcomes and other follow up contacts related to the call.

6. The development and implementation of a written protocol to ensure residents' diagnostic and laboratory test results are signed when received and immediately reported to the primary or on-call physician if the results are outside of the normal values noted on the report.

7. The development and implementation of protocols to ensure the NM on duty is accessible to the registered staff at all times during the shift. If they are not available, there must be a back up registered staff available for support.

8. The development and implementation of written protocols to ensure registered staff notify the resident or the resident's SDM when a resident experiences a change in condition.

9. The development and implementation of a written tool for person to person shift report. This tool must include, but is not limited to, what time person to person shift reports occurs, what information is expected to be provided during report and who should attend shift to shift report. This tool will be utilized for all shifts, required to be signed off at the end of each shift to shift report and should be readily accessible at all nursing stations.

10. The development and implementation of a protocol to ensure registered staff are aware of all residents level of care or code status at the beginning of their shift.

11. The development and implementation of a written protocol to manage

wandering residents and their access to other resident's rooms and personal belongings during an outbreak.

12. A review conducted by the interdisciplinary team of all written plans of care for residents who wander and ensure appropriate interventions and strategies are in place to minimize wandering risk utilizing best practice guidelines. A written record of who attended the review, date of the review, which residents were discussed, and any changes made to a resident's plan of care must be kept.

13. The development of a written procedure to be implemented when any resident is noted to have a change in health condition. This procedure must include, but is not limited to the following:
-Responsibilities of registered staff when a change in health condition in a resident is noted;
-What assessments are to be initiated and completed;
-Who must be contacted and notified; and
-How staff should document the implementation of the procedure.
-A description of training and education that will be provided to all direct care staff on the written process mentioned above. Indicate who will be responsible for providing education, and the dates this education will occur. This written procedure will be utilized for all shifts and should be readily accessible at all nursing stations.

14. The development of an on-going monthly auditing process to ensure that all physician and/or nurse practitioner (NP) orders are completed with appropriate documentation. Conduct an analysis of the audit and provide follow up education to staff as required. Maintain a written record of the audits and analysis. Include who will be responsible for doing the analysis, and outcome of the analysis.

Please submit the written plan for achieving compliance for inspection #2020_780699_0014 to Praveena Sittampalam, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by September 25, 2020. Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

## 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

(A1)
1. 1. The licensee has failed to ensure residents #002, #003, #009, #006 and #014 were protected from neglect by the licensee or staff in the home.

For the purposes of definition 'neglect' in subsection 5 of Ontario Regulation 79/10 means, the failure to provide a resident with the treatment, care, service or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

The Ministry of Long-Term Care (MLTC) received a complaint, related to staffing shortages, outbreak management, lack of Personal Protective Equipment (PPE) for staff and care requirements of residents not being met.

An identified communicable disease outbreak was declared at the home by Public Health. Ongoing concerns regarding the management of the outbreak were being reported to the MLTC which included not managing residents who were wandering around the units potentially spreading the infection.

Residents #003 and #009 had a history of a specified responsive behaviour prior to the outbreak.

a. On an identified date, documentation in the residents clinical record indicated that staff observed the resident walking up and down the hallway. The resident was then observed grabbing a co-resident's walker in their room and staff had to intervene to minimize the risk of the co-resident falling.

Documentation in resident #003's electronic health records indicated on day two, the resident had a symptom of infection and was administered a specified medication. There were residents on the unit that had been confirmed positive for an infection at this time. The resident continued to exhibit a specified behaviour and did not stay in their room. The nurse manager was informed; however, no interventions were implemented.

On day three, the resident was tested for the presence of an infection.

On day four, documentation indicated that the resident was in contact with residents who were positive for an infection. The intervention documented was to keep

monitoring.

On day five, the test results received showed resident #003 was positive for the identified infection.

On day 10, NP #115 ordered a specified treatment for resident #003 due to their poor intake.

On day 11, resident did not receive their specified treatment due to a lack of availability of supplies on the unit to start this treatment.

During an interview, NP #115 stated that they notified ED #100 on day 12 that supplies were not available for the specific treatment to be administered, and that the ED responded that supplies were available but that they were stored in the boardroom. According to the NP, the ED also indicated that the RPN should have contacted the Nurse Manager (NM) to obtain the supplies.

NP #115 stated that during one of their on-site visits, they observed that there was a shortage of staffing, staff were too busy and should have had supplies available on their units, and that not all staff were aware of the process to access supplies due to little to no orientation.

During an Infection Prevention and Control (IPAC) Assessment conducted by the Public Health Inspector (PHI) #139, it was noted in this report that there were many residents wandering the halls within the different units. Staff were not able to re-direct residents to their rooms or practice social distancing.

The IPAC Assessment also indicated that residents had not been identified as being on droplet/contact precautions when necessary, not all staff were aware that all residents were on droplet/contact precautions and that full personal protective equipment (PPE) was required to be worn for all direct care of residents.

Staff were not able to provide dedicated (cohort) care to only infected residents as units were a mix of positive and non positive infection cases. Staff were moving from resident to resident and unable to always provide consistent cohort care.

During the outbreak, resident #003 continued to move about the unit and was

witnessed with co-residents despite being on isolation precautions.

Staff #106 was identified as working on this unit. During an interview with staff #106, Inspector #508 asked the staff if they were aware at the time that the resident was on isolation precautions. Staff #106 indicated yes, but there was nothing you could do.

b. On an identified date (day one) during the communicable disease outbreak, documentation in resident #009's record indicated that they were in close contact with resident #003.

Documentation indicated that on day seven, resident #009 was in the hallway most of the night and refused re-direction back to their room. The staff attempted to explain to the resident that they needed to remain in their room; however, this was unsuccessful.

On day eight, resident #009 was swabbed for the presence of an infection.

On day nine, it was documented that resident #009 kept in contact with other residents that were positive for infection.

On day 10, resident #009 test result came back positive for infection.

On day 11 and 12, it was documented that resident #009 was found in other resident rooms and at the nursing station.

During interview with staff #112, they also confirmed that they observed residents wandering in and out of resident's rooms during the outbreak. They also stated that they did not have enough staff to meet residents' care needs as they were so short staffed.

The only intervention included re-direction of these residents and keeping doors closed between units with signage applied to the doors.

On an identified date during the communicable disease outbreak, LTCH Inspector #535 observed these doors to be open during a tour of the unit.

It was confirmed during review of documentation including resident clinical records,

IPAC assessments, during interviews with staff and through observations that residents #003 and #009 were not protected from neglect by the licensee.

2. The MLTC received a complaint related to improper assessment of resident #002.

Record review of the progress notes indicated that on a specified date, RPN #106 assessed the resident and documented that the resident had a change in health condition.

During an interview, RPN #106 verified that they attended the resident's room when they were alerted by a PSW that the resident was not looking good. The staff stated the following: It was almost time for their shift to end. They took the resident's vital signs and it was not too bad. The staff verified that they did not contact the family or the physician prior to leaving at the end of their shift. RPN #106 also stated that although they don't really do a shift report with the oncoming nurse, they explained to the nurse what was happening, they did not go back to the resident's room prior to leaving. The nurse stated that everybody in the home was sick and nobody was doing anything; they were just an agency nurse; they were the only nurse on the unit that day; and that they may have tried to call the nurse manager (RN), but usually nobody would answer the phone. When asked what the expectation was when a resident had a change of condition, the RPN stated they should have taken responsibility and called the charge nurse, the family and the physician, then follow through with the physician's orders and the family's request.

During an interview, RPN #109 verified that they worked the following shift, however they did not receive a shift report from RPN #106. The staff continued to say: most agency nurses do not know the residents well; RPN #106 did not inform them that resident #002 was experiencing a change in condition during their shift. Later during the shift a PSW alerted RPN #109 that the resident was not looking good. They attended the room, assessed the resident, took their vital signs and they thought the resident was fine. The RPN stated the resident did not look like they were in any distress.

RPN #109 stated that during the eight hours shift the resident refused their medication, meals, and fluids; and usually when the resident refuses to eat, they would drink the supplement ordered by the registered dietitian (RD). The RPN acknowledged that during the shift, the resident refused the supplement, and they

returned to the room multiple times to encourage the resident to drink, but they kept refusing. When asked if they were concerned that the resident was lethargic, the staff answered no, because over the past week the resident was usually sleepy. According to the RPN, the same situation happened one week prior, and the DOC called the family at that time and things were fine. Therefore, this time they did not call the family or the physician since the same situation was happening again. The registered staff also confirmed that they did not notify the RD that the resident was refusing the supplement. The staff acknowledged that at the end of their shift, they reported to the oncoming nurse that the resident refused their medication, food and fluids during the shift, and that they had experienced some change in condition during the previous shift, therefore please monitor the resident.

The registered staff who worked the next shift, was not available for an interview during this inspection; however, there was no documentation in the progress notes related to this resident's condition during the shift.

The next day, RPN #106 documented in the progress notes the resident was experiencing a change in condition. The physician was notified and a diagnostic test was ordered. RPN #106 documented in the progress notes: Phone call received from resident's power of attorney (POA). Requested that resident be transferred to the hospital. Will ask the oncoming shift to follow up. During the interview, RPN #106 verified the information as documented above.

During an interview, RPN #107 acknowledged that they received a report from RPN #106. Towards the end of their shift, RPN #107 documented that the resident was experiencing a significant change in condition and called POA and informed about the resident. The POA wanted the resident transferred to hospital, so 911 was called and the resident was transferred to the hospital.

During the interview, RPN #107 acknowledged their documentation as noted above. The RPN recalled that at the beginning of their shift, RPN #106 reported that two residents needed to be transferred to hospital. RPN #107 recalled that they assessed resident #002, completed their vital signs, called the substitute decision-maker (SDM) for permission to transfer the resident, called 911 and sent resident #002 out to hospital shortly after they started their shift. RPN #107 stated that during the shift report, RPN #106 informed them that they could not send the resident to hospital because they were from the agency.

Record review of the staff schedule and an email from Scheduling Clerk #149 verified that there was no nurse manager/registered nurse working in the building when the resident was transferred to hospital.

During an interview, ED #101 verified that based on the assessment of the resident and the resident's required level of care - full code status, RPN #106 should have called the family and the physician, and transferred the resident to the hospital. The ED verified that a full chart review was completed and the RPN was given discipline as a result of their investigation. The ED acknowledged that the RPN's pattern of inaction was consistent with the home's definition of neglect. [s. 19. (1)]

3. The MLTC received a complaint related to care concerns regarding resident #006.

Record review of the progress notes indicated that resident #006 showed identified symptoms of infection and was treated with an identified treatment. Record review of the progress notes indicated that a diagnostic test was indicated but was not collected and sent to the Public Health Lab until three days after onset of symptoms by NM #138. The physician and SDM were not notified of the symptoms until three days after onset at which time the on-call physician ordered several diagnostic tests.

During an interview, RPN #116 stated that they could not recall if they reported the resident's symptoms to the NM, however, they did not notify the physician or the family at that time since they administered a treatment for the symptom. The nurse documented an unknown response when the medication was administered. There was no documentation in the progress notes to indicate resident's change in condition was reported to the nurse manager, the family or the physician.

During an interview, NM #138 verified that they collected and sent the swab as documented. They also verified that when a resident had the identified symptoms, the RPN should report it to the NM in charge of the building, a specific diagnostic test should be collected and sent to Public Health, and the resident appropriately isolated immediately.

A review of the progress notes and the resident paper chart showed no results were available for the diagnostic tests which were ordered by the on-call physician. ED #101 verified that the home was unable to locate both test results. The SDM

requested and the resident was transferred to the hospital for treatment five days after the symptom onset.

During an interview, ED #101 verified that if a resident was exhibiting a symptom of an identified infection, they should have been swabbed the day they started displaying the symptom. The ED acknowledged that there were also gaps in care and service related to the collection of swabs. The gap was that part of the home's initial action plan specified that only the infection prevention and control (IPAC) lead would collect swabs, and when that staff was off work for an extended period, and the other nurse managers required training related to how to collect the swabs. The ED acknowledged the pattern of inaction described above fits the definition of incompetent resident care and neglect of resident #006. [s. 19. (1)]

4. The MLTC received a complaint related to care concerns and protocols not being followed regarding resident #014.

Record review of resident #014's progress notes indicated the following on an identified date (day one), the resident tested positive for an infection; registered staff identified reduced food and fluid intake, registered staff continued to administer the resident's prescribed which was a diuretic (water pill) despite the resident's poor fluid intake, until the medication was discontinued by the physician on day six. On that date, the RD and the primary care physician were alerted to the resident's status after the SDM sent an email to ED #100 outlining their concerns.

Physicians #129 and #131 ordered identified interventions in response to the SDM's documented concerns and their follow up assessments of the resident. Record review indicated the resident passed away in the home on day 11.

A) As indicated in the collaboration findings under s. 6 (4) (a), during separate interviews, RPNs #109, #113 and #124 verified that they did not send a referral to the home's RD when the resident was noted to have reduced food and fluid intake over a number of days to one week.

B) During an interview, RPN #124 verified that they administered a specific diuretic medication to the resident during the same period when the resident was refusing food and fluids. The RPN verified that they administered the medication to the resident, as was evident by their signature on the resident's eMAR. The RPN

acknowledged that diuretic medications can cause the resident to pass more urine, and that if the resident had reduced fluid intake that could promote an identified condition. The staff also stated that the registered staff who worked the night shift was to monitor residents' fluid intake and place them on hydration monitoring if the resident's intake was less than adequate, but that might not have happened given the limited staffing at that time.

C) RPN #124 also acknowledged that one of the side effects of taking a diuretic or water pill could be low electrolyte level. However, the RPN was not able to accurately state what interventions were used by the home to treat the resident's low blood electrolyte level. The laboratory document was date-stamped as received on a specific date; however, the physician signed and dated the document four days later, after the resident passed away. ED #102 verified that there was no order written in the resident's chart to support treatment of their low electrolyte level.

D) During an interview, RPN #113 and #137 both verified that because the resident was refusing oral intakes, the route of medication administration was changed. Both RPNs documentation on the resident's eMAR and in their progress notes indicated that for four days, the specified medication was not administered because the home did not have the medication in stock nor did they have a supply of sterile water to reconstitute the drug for injection. As a result, the resident missed four out of the first five doses of the medication. ED #101 verified that there was no incident reports completed by registered staff related to those missing doses of medications.

During separate interviews, RPN #124 and ED #101 acknowledged that there was a pattern of inaction by registered staff on the unit as documented above. RPN #124 stated that because of the pattern of inaction shown above it would be considered neglect. The ED also verified that this pattern of inaction by registered staff constituted neglect.

Therefore, the home failed to ensure residents #002, #003, #006, #009 and #014 were protected from neglect by the licensee or staff in the home.

The severity of this issue was determined to be a level 4 as there was serious harm to the residents. The scope of the issue was a level 3 as it was related to seven out of nine residents. The home had a level 3 history as there were previous non-compliance to the same subsection that included:

## 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

-Compliance Order (CO), issued February 28, 2018, 2018_712665_0003; and
- Written Notification (WN), issued April 18, 2019, 2019_631210_0008. (508)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Mar 15, 2021(A4)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 004

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

**Order / Ordre :**

The licensee must be compliant with s. 31. (2) of the O. Reg. 79/10.

Specifically, the licensee must:

-Ensure that there is a written finalized staffing plan for the Nursing and Personal Support Services programs that is developed with the appropriate members of the interdisciplinary team.

**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

**Grounds / Motifs :**

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services program.

Complaints were reported to the MLTC related to staffing shortages, outbreak management, lack of personal protective equipment (PPE) for staff and care requirements of residents not being met.

An identified outbreak was declared in the home on a specified date. Complainants were concerned about the lack of nursing staff resulting in residents not receiving the care they required.

During the course of this inspection, it was identified that the home was experiencing a shortage of nursing staff and the home had hired over 70 new staff through various agencies.

The LTCH Inspectors requested a copy of the home's most recent staffing plan on June 4 and again on June 8, 2020. This was not provided to the LTCH Inspectors until June 11, 2020.

After review of the staffing plan, it was identified that the plan was in draft form and had not been finalized. During the outbreak, residents were isolated to their rooms and many required assistance with their meals and had additional care requirements. The staffing plan that was provided during this inspection did not include what actions would be taken to ensure the care requirements of the residents were met.

The LTCH Inspector confirmed with the Interim DOC that the home did not have a final or formalized staffing plan for the nursing and personal support services programs at the time of this inspection.

The severity of this issue was determined to be a level 2 as there was minimal harm/risk to the residents. The scope of the issue was a level 3 as it was related to the whole home. The home had a level 2 history as there were previous non-compliance to a different subsection. (508)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 26, 2020(A2)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

## Order(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

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**Order # / No d'ordre:** 005

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 44. Every licensee of a long-term care home shall ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents. O. Reg. 79/10, s. 44.

**Order / Ordre :**

The licensee must be compliant with s. 44 of the O. Reg. 79/10.

Specifically, the licensee must do the following:

-Develop a written protocol to ensure registered staff have immediate access to supplies, that includes but not limited to, intravenous fluids, butterfly needles, sterile water and emergency medication from the Emergency Stat Box as required to provide resident care.

-Ensure that supplies, equipment and devices are readily available at the home to meet the nursing and personal care needs of residents.

**Grounds / Motifs :**

1. The licensee failed to ensure that supplies, equipment and devices were readily available at the home to meet the nursing and personal care needs of residents.

A complaint was reported to the MLTC, related to staffing shortages, outbreak management, lack of personal protective equipment (PPE) for staff and care requirements of residents not being met.

Documentation indicated that on a specified date, resident #003 had decreased food intake and was sleepy. The RD completed an assessment, interventions were implemented to address the requirement for an increase in calories and fluids.

NP #115 identified that the residents' intake for food and fluid continued to decline. A

specific treatment was ordered for five days. Progress notes indicated that the resident refused the treatment.

The following evening, RPN #111 attempted to start the specified treatment as ordered; however, could not find supplies on their unit. They indicated during interview that there were no specific equipment required for the treatment available. It was documented in the progress notes on the resident's electronic health record, that no supplies were available.

During interview with NP #115, they indicated that they were alerted to the issue of staff not having the equipment to provide this treatment and brought forth this concern to the ED.

During interview with the DOC #102, they indicated that they had supplies on the main floor and the RPN staff should have called the Nurse Manager to access these supplies.

Due to the lack of orientation staff #111 was unaware of this process.

During a discussion with Interim ED #116, they agreed that this process especially during the outbreak was not the best process.

After this was identified and after discussion with the DOC #102, the Canadian Armed Forces (CAF) report dated June 21, 2020, with a review period from June 14 to June 20, 2020, also identified that the home did not have the equipment required to administer the specified treatment.

WOD #104 was able to arrange to borrow these supplies from the local hospital.

It was confirmed through review of the resident's clinical record, review of the CAF report and interview with RPN #111 that supplies were not readily available to meet the nursing and personal care needs of the residents.

The severity of this issue was determined to be a level 2 as there was minimal harm/risk to the residents. The scope of the issue was a level 3 as it was related to the whole home. The home had a level 2 history as there were previous non-compliance to a different subsection.  (508)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Oct 26, 2020(A2)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 006

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 46. Every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario. O. Reg. 79/10, s. 46.

**Order / Ordre :**

The licensee must be compliant with s. 46 of the O. Reg. 79/10.

Specifically, the licensee shall ensure the following:

- Prior to training and orientation in the home and yearly thereafter, ensure that every registered nursing staff (Registered Practical Nurse and Registered Nurse) has the appropriate current certificate of registration with the College of Nurses of Ontario.

## 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

**Grounds / Motifs :**

1. The licensee has failed to ensure that every registered nursing staff (Registered Practical Nurse) had the appropriate current certificate of registration with the College of Nurses of Ontario.

During the course of the inspection, the Long Term Care Homes (LTCH) Inspectors received a list of recently hired staff whom were hired through various staffing agencies. The staff consisted of registered and non-registered nursing staff.

It was identified during review of the registered staffing credentials that RPN #113, who had been hired through the agency was not entitled to practice according to the College of Nurses of Ontario (CNO); however, that staff had worked as an RPN in the home for two weeks.

RPN #113 was identified in WN #3 related to neglect of resident #014 resulting in actual harm/risk to the resident and WN #7 related to not reporting of a medication incident. Please see WN #3 and #7 for further details.

The LTCH Inspector requested that the managers of the home follow up when this was identified and also confirmed that the RPN was not scheduled to work at the home to ensure the safety of residents. On June 19, 2020, ED #101 confirmed with Inspector #508 that the agency did not do the appropriate screening and the home also did not check their registration with the CNO to ensure they were entitled to practice prior to them working in the home.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 1 as it was related to one out of three staff. The home had a level 2 history as there were previous non-compliance to a different subsection. (508)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 12, 2020

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 007

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

**Order / Ordre :**

The licensee must be compliant with s. 135. (1) of the O. Reg. 79/10.

Specifically, the licensee shall ensure the following:

-The development and implementation of a written medication incident protocol or guideline. This protocol must include, but not limited to the following:
-When a medication incident must be filled out;
-Who is contacted when a medication incident occurs; and
-How and where a medication incident is documented.

This written protocol or guideline should be readily accessible at all nursing stations.

**Grounds / Motifs :**

1. The licensee has failed to ensure that every medication incident involving a resident and every adverse drug reaction was documented, together with a record of

the immediate actions taken to assess and maintain the resident's health, and reported to resident #014's SDM, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug and the pharmacy service provider.

A) Record review of the resident's eMAR and the Digital Prescriber's orders form indicated that resident #014 was ordered a medication for ten days. The resident's eMAR indicated the medication was not administered and was left blank with no signature or code to explain why the medication was not administered for five days as supplies were not available. Therefore, the resident missed four out of the first five doses of the medications ordered by the physician to support their treatment. On August 12, 2020, an email was received by Inspector #535 from IDOC #140 verifying that incident reports were not complete for the above medication incidents until recently; and the physician and resident's SDM were not notified.

B) Record review of the resident's food and fluid intake sheets indicated that resident #014 was eating and drinking poorly. A review of the resident's eMAR indicated that registered staff continued to administer a diuretic medication (water pill). In an interview, ED #101 acknowledged that the nursing staff should have notified the physician to hold the medication based on the resident's poor food and fluid intake. Record review indicated a medication incident report was not complete, and the physician and family were not notified.

C) Record review of resident #014's eMAR indicated that RPN #113 administered a pain medication to the resident on an identified date. During an interview, physician #131 stated that they had given a telephone order for a specific pain medication; however the registered staff wrote an incorrect medication. During an interview, NM #138 and DOC #102 verified that the amount of the incorrect medication administered by RPN #113 was more than they had seen administered to a resident in the home. DOC #102 further stated that there should have been an incident report completed related to the amount of the incorrect medication administered. Furthermore, the DOC stated that there should have been a follow up investigation to see if the error was related to a nurse transcription error or an error related to the physician's order. Record review indicated that a medication incident report was not completed, and the physician and family were not notified that of the medication incident. The physician discontinued the incorrect order the same date the order was written.

Therefore, the home failed to ensure the medication incident was documented, together with a record of the immediate actions taken to assess and maintain the resident's health, and reported to resident #014's SDM, the Director of Nursing and Personal Care and the Medical Director and the pharmacy service provider.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 1 as it was related to one out of three residents. The home had a level 2 history as there were previous non-compliance to a different subsection. (535)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 26, 2020(A2)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 008

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must be compliant with s. 229. (4) of the O. Reg 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that all staff participate in the implementation of the Infection Prevention and Control (IPAC) program. This plan must include:

1. An audit tool that will be utilized to monitor staff compliance with the Public Health Ontario education related to appropriate donning and doffing of PPE and hand hygiene as required.

2. The development of a written protocol that on every shift, until further notice, all staff wear the appropriate PPE that has been directed to be worn by the home in conjunction with input by the Public Health Unit, while working on resident care units; and follow the home's IPAC protocol/policy.

3. What steps the home is taking to ensure that the home is in compliance, and maintains continued compliance, with all sections of the York Regional Public Health Order, made pursuant to Section 29.2(1) of the Health Protection and Promotion Act, issued to the home in May 2020.

4.The development of a written process to ensure that the home has adequate supplies of personal protective equipment in the home. This process must include, but is not limited to, the quantity of each personal protective equipment, the amount of any surplus equipment, the required amount of PPE to adequately provide all staff in the home, who to contact for escalation if there is a PPE shortage, who is conducting the data collection, the date it was conducted, the frequency, and the actions taken as a result.

Please submit the written plan for achieving compliance for inspection #2020_780699_0014 to Praveena Sittampalam, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by September 25, 2020. Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. 1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

An identified communicable outbreak was declared at the home by public health. Complaints were received at the MLTC related to the outbreak management at the home.

During an identified time period, several Infection Prevention and Control (IPAC) assessments were conducted in the home by William Osler Hospital and York Regional Public Health and some of the home's management staff.

A review of the IPAC Assessment report, indicated that staff were not using PPEs as required and were not practicing social distancing. The assessment indicated that approximately 40%-50% of staff were wearing an identified mask, and that only one mask was provided for staff to be worn during their shift. Some were bringing their own and others were offered from the facility. The identified masks were not being changed after direct contact with residents positive for infection and negative residents and unclean identified masks were being re-used by staff after their breaks.

Some lunch rooms did not have masks for the staff to put on in the lunch room after having a meal.

Staff had to go into the hallway without a mask to find one.

It was also noted in this report that there were many residents wandering the halls within the different units. Staff were not able to re-direct residents to their rooms or practice social distancing.

Residents had not been identified as being on droplet/contact precautions when necessary. Not all staff were aware that all residents were on droplet/contact precautions and that full PPE was required to be worn for all direct care.

Staff were not able to cohort care to only positive residents as units were a mixture of both positive and negative infection cases. Staff were moving from resident to resident and unable to always provide continuous cohort care.

It was identified during this report that staff required education regarding the proper use of PPE, including donning and doffing.

Staff who were recently hired indicated during interviews that they received little to no

orientation prior to working at the home.

After the outbreak was declared, residents who were positive for a specified infection were cohorted to a specific unit.

The unit was separated by doors and caution signage was applied; however, on June 2, 2020, Inspector #535 toured the facility and identified that although the doors were to be kept closed, they were observed to be open.

NP #115 was working onsite at the home and identified that there were not enough hand sanitizers for staff and that the nurse administering medications had an empty bottle of hand sanitizer. PSW staff advised the NP that many of the hand sanitizers were empty or the dispensers were not working. They also observed that there were not enough garbage bins to dispose of used PPEs.

On May 31, 2020, an order was issued to the home and the licensee by York Region Public Health.

In a section of the order, it identified that they had received documentation that the home had inadequate and/or insufficient infection prevention and control (IPAC) knowledge and processes to protect resident needs. The home required assistance from York Region Public Health and the Central West Local Health Integrated Network (CW-LHIN) to attend the home and provide IPAC expertise and education for staff, to ensure residents received the necessary care and treatment required to contain the spread of infection during the outbreak.

On June 2, 2020, IPAC Extender #128 who was working in the home identified ta room with a resident on droplet/contact precaution did not have a PPE caddie in place; and on one unit, a fan was observed in a resident's room.

During an interview, staff #112 who had been recently hired stated that they only worked a couple of shifts in the home and that they would not be returning to work in the home again due to the lack of orientation and PPE availability to front line staff.

They indicated that there were only two PPE caddies set up on the unit; however, majority of the residents living on the unit were positive for a specified infection. They also stated that surgical masks were not made readily available. And, they were told

to wear one surgical mask per shift; and if the mask was soiled, they could get another mask but had to request it from the Nurse Manager (RN) on duty.

During one of the shifts, the staff indicated their surgical mask broke and they had to wait approximately 30 minutes to get another mask as the RPN was busy administering medications to residents.

The Canadian Armed Forces (CAF) team who were deployed to the home also identified IPAC issues in the home. They reported staff not complying with screening policies when entering the facility. PSWs were observed providing care to residents without gowns, and a snack cart was delivered to a positive unit mistakenly, then sent to a negative unit in a report dated June 28, 2020.

It was confirmed through review of documentation, observations and interviews that staff did not participate in the implementation of the home's infection prevention and control program. [s. 229. (4)]

2. On May 31, 2020, the Medical Officer of Health from the Regional Municipality of York issued an order under Section 29.2 (1) of the Health Protection and Promotion Act, to the home to take the following action related to active surveillance:

Ensure staff are trained on the appropriate use of personal protective equipment and tools and follow directions on the use of PPE as provided by York Region Public Health, William Osler Health System, Public Health Ontario, and the Central West Local Health Integrated Network (CW-LHIN).

During three separate tours conducted in the home on June 2, 3, and 7, 2020, Inspector #535 observed multiple concerns on all home units related to infection prevention and control as follows:

a. Resident #018 whom staff identified as positive for a specified infection was standing at the nursing station, wandering the hallway and coughing intermittently. PSW was informed.
b. Activation staff #130 voiced uncertainty of what personal protective equipment (PPE) to wear when going into residents' rooms to serve the meals, asking if they should wear full PPE or just a mask and face shield.
c. Observed second wandering resident using a walker in the hallway beyond the

locked doors.
d. Observed garbage containers overflowing onto the floor with used PPEs such as gowns and gloves. Housekeeping staff was informed.
e. Observed physician #131 who assessed a resident and was searching for a working hand sanitizer dispenser to clean their hands. The physician entered three residents' rooms and containers were empty. They finally found a hand sanitizer with solution down the hall and around the corner.
f. Observed three residents sitting beside each other in a TV lounge with no social distancing between them. Inspector was informed by staff that they were wandering residents. Registered staff had informed the inspector upon entry to the unit that there were five or six residents who were negative still residing on the positive unit at that time.
g. Observed resident #013 wandering in and out of other residents' rooms throughout the unit, touching side rails, sitting in other resident's room in the chair and on their bed. Also observed that the double doors separating the unit were left opened.
h. Observed PSW #132 walking around on the unit with two supermarket plastic bags tied on their feet to use as shoes cover. When asked why, the staff stated that booties were not available to cover their shoes while working on the unit.
i. Observed that home units did not have enough hampers for staff to discard PPEs upon removal when exiting residents' rooms.
j. While checking random dispensers throughout the home, observed that hand sanitizers were empty.
k. Observed one staff wearing two yellow cloth gowns and full PPE inside the nursing station. When asked why they were wearing full PPE in the nurses station since it was designated a clean area, Activation Staff #133 stated that they were not aware that they could not wear their gown in the nurses' station because they were away from the home, and had just returned back to work today. The staff was wearing two gowns, two surgical face masks and a face shield.
l. Observed multiple residents wandering in the hallways on two units.

While conducting this on-site inspection, Inspector #535 was provide with three different IPAC practice change of instructions related to what PPE to wear when entering affected resident care units.

During an interview, IPAC Extender (IPACE) #128 stated that they were from the CW-LHIN. And, they would be on-site daily for the next few weeks to support the home by conducting hand hygiene audits and infection prevention and control

education support to staff, in small groups and one on one during walkabouts on various residents home areas. IPACE #128 stated that they frequently had to remind staff of the appropriate use of PPE, but that was a part of their role in the home.

During an interview, RPN #105 stated that there was a time when they would get only one mask for the day sometime around the beginning of May 2020. They would get the mask at the entrance during screening; and they would have to wear the mask for the entire shift; if they needed more PPE, they would have to call the nurse manager on duty. The staff stated they did not have gowns at that time, and they had some gloves, but they had to minimize there use so that they would not run out. The staff stated that the large gloves were going very fast; and some staff were vocal about the lack of PPE supplies that were made available to direct care staff on the units.

During an interview, IPAC Lead #103 stated that after the previous DOC left the home in March 2020, they co-shared the IPAC Lead role with the current DOC #102. IPAC Lead #103 verified that the home was declared in outbreak and that two wandering residents on two floors initially tested positive for infection. The IPAC Lead stated that ten days later, 22 residents tested positive and now there was a mixture of positive and negative residents on all units which posed a challenging issue with wandering residents living on each home area. The IPAC Lead stated that with directions from their corporate office, wandering residents were moved to the rooms before the closing fire doors; however those residents would remove yellow wander strips from across room entrances, and whenever the fire doors were left open, they would wander back and forth in the hallways and into other residents' rooms. The IPAC Lead stated that the home tried to recruit students to support one to one monitoring, but they would come one day, then not show up for next shift. The ADOC stated that the team talked about housing all wandering residents on one unit, however they were concerned about possible effects of moving them to a new environment which might escalate their responsive behaviors. Therefore, on one unit, Activation Staff #133 was scheduled to keep wandering residents engaged. They also tried to create an illusion of a black hole by putting black strips of tape on the floor in front of their room doors and in front of the double fire doors. They also used anti-psychotic medication to control their wandering behaviors, however these strategies worked sometimes but they were not fully effective.

During an interview, Supporting DOC #117 (SDOC) stated that they encountered

some conflicting IPAC information and practices when they entered the home. The information was mainly related to inconsistencies in the use of infection control signage. For example, the use of PPE when donning and doffing; and displaying of droplet/contact isolation signage on residents' doors - the home was advised to put droplet/contact signs up on all resident doors in the home, and to display donning and doffing signs on all resident's door. According to the SDOC, they were told this by the York Region Public Health team. The rationale provided was because the whole home was in outbreak, therefore all residents should have the sign up whether they were positive or negative for infection. However, SDOC #117 thought that if they were really trying to be consistent and sure that staff comprehended the IPAC education being provided, they should know why they were performing that task, and that information was not provided to them. Therefore, the home was posting signs for all positive and negative residents' room doors. So, the only thing that would distinguish positive and negative residents on the units were the addition of a specified marking to signify positive residents.

The SDOC further stated that staff understood the importance of donning and doffing of PPE; however they were provided with multiple change in directions related to what to wear when providing direct care to residents, short visits to a resident's room, walking in the hallway and working in the nurses station. The SDOC stated that during that time, there was a lot of confusion amongst the staff. And, even they were confused related to the proper use of PPE since many different instructions were discussed and implemented in terms of PPE use of goggles, face shields, mask and gloves.

During an interview, DOC #102 stated the following: after the outbreak was declared, residents condition were stable; physicians saw residents who staff identified as high risk and the ED and DOC rounded every day to speak with staff. Then on the designated "infection unit" staff members started saying they were going to leave and not return to work because of the high risk of exposure or transmission to their families at home. But that soon settled when a staff member was hired to monitor and support wandering residents. The DOC stated that everything changed when a Public Health Investigator (PHI) #139 visited the home unannounced. They conducted a walkabout and immediately started correcting staff members infection control practices by telling them that they were not doing the right things, and that they were doing opposite to what they should have been doing related to PPE and infection prevention and control practices. Team members went from knowing what

mask and other PPEs to wear, to being completely confused. The DOC stated that PHI #139 told staff to change their mask after provision of care to or contact with each resident; however, by that time, the home had already cohorted positive residents therefore that did not need to happen, and it was not in alignment with the homes's practice. There was also no agreement regarding the use of face shields. PHI #139 stated that when staff leave the resident's room, they should remove and wipe the face shield, then wait for one minute before putting it back on to enter another resident's room. The DOC stated that was taking time away from resident care and it was causing self-contamination. The DOC stated that there was confusion and conflict related to the IPAC information and education received in the home prior to PHI #139's visit. And, the home did not receive an IPAC report from PHI #139 related to that visit.

According to the DOC, the confusion did not help and staff members started wearing PPEs inappropriately. The DOC stated that they sent an email to their clinical support staff because York Region Public Health (YRPH) instructions appeared to be different from the home's infection prevention and control teaching, which was in alignment with Peel Regional, Toronto and Muskoka Public Health IPAC information. The DOC also stated that their corporate office IPAC leads provided virtual and onsite IPAC re-education for all staff members to rebuild trust and clear up any miscommunication. However, staff members were upset and voiced that they were scared because they came in to work to do their best but that they were being put at risk. The DOC stated that was when their positive resident cases started to increase.

DOC #102 verified that there was inappropriate use of PPE by staff members and the inability to contain wandering residents on the resident care units, contributed to the steep climb of positive resident cases, and the situation was a continuous challenge. They verified that they were rationing face masks for staff in the home since the ministry asked long term care homes to keep a record of their daily use, and they were being conservative. They also confirmed that they were in the middle of the home's outbreak when PPE supplies were made accessible to staff on the units, however mask and gloves were always made available in the resident care units. The DOC further confirmed that as per their corporate office directive, staff were provided with one mask but if the mask was soiled or broken, they could get a new mask by calling and requesting one from the nurse manager on duty.

Therefore, the home failed to ensure that staff participated in the implementation of

the infection prevention and control program.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 1 as it was related to the whole home. The home had a level 2 history as there were previous non-compliance to a different subsection. (508)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 13, 2020(A2)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 009

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

**Order / Ordre :**

The licensee must be compliant with s. 31. (3) of the O. Reg. 79/10.

Specifically, the licensee must:

-Provide for a staffing mix that is consistent with residents assessed care and safety needs;
-Set out an organized staffing schedule;
-Promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
-Include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work;
-Update and evaluate the written staffing plan at least annually.

**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

**Grounds / Motifs :**

1. The licensee has failed to ensure the home's staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Record review of the home's Staffing Plan in draft and the Nursing Daily Schedules indicated that the level of staffing was below adequate numbers and staff mix to support residents' assessed care and safety needs during a specific period of time.

A review of the Nursing Daily Schedules for that same period indicated there were direct care staffing shortages in the home daily. The number of direct care staff members available to provide safe and competent assessment and care of residents, as well as the appropriate staffing mix that was consistent with residents' assessed care and safety needs were less than indicated in the draft staffing plan during normal times. The Inspector also noted that the original Nursing Daily Schedule for a specified date was missing and unavailable for review during the inspection as verified by the home's Scheduling Clerk #149.

During separate interviews, RPNs #105, #106, #109, #113 and #124 verified a significant staffing shortage in the home during that stated period. RPN #106 who was new to the home stated that during that period, they never worked with a full complement of staff on the various units which they were assigned. The staff stated that sometimes they would call the nurse manager to request support and they were told that they do not have any more staff so do the best you can. The staff recalled coming in to work the day shift after a night shift when only one PSW had worked on the unit. The RPN described significant care concerns.

During separate interviews, NM #103 and #127 acknowledged the staffing shortage was of concern; and described a significant staffing shortage on an identified week-end. NM #103 stated that staffing levels were ok for a while after the outbreak was declared, but after a specified date it became an increasing challenge to staff the units. They stated the home redeployed all nurse managers to work on the units as staff nurses, and that the management team was in touch with their human resources staffing partners at the corporate office. The NM verified that they never used agency staff before, but they started hiring and using agency staff. The nurse manager recalled one shift when they worked on the unit with one PSW, and described the experience as challenging since residents were drowsy and there were challenges related to medication administration and feeding residents in their rooms,

while trying to support all other registered staff in the building as the only registered nurse.

During an interview, NP #115 stated that while working remotely to complete residents' assessments, it was a challenge to get a hold of staff on the units to discuss how residents were looking and doing so that the information could be reported to their families. The NP stated while they were onsite assessing residents' in the home, nurses were on the unit and providing care as best as they could while working with all that they had because they were short staff and were not allowed to leave their units. The NP stated that if the staff needed additional supplies, they had to call the resource nurse to locate and bring the supplies to the floor.

During an interview, Physician #129 acknowledged the staffing shortage was an issue since staff were calling in sick, not showing up to work their shift or were in self-isolation as a result of an identified infection. The physician also acknowledged that during the outbreak the home required an increase in staffing complement to manage the situation. The physician verified that on an identified date, several residents were transferred to acute care hospitals in the surrounding area following assessments completed by William Osler's medical and nursing teams because "we were over our heads" - the home was not able to provide residents with the level of care they required due to a lack of registered nursing staff and PSWs. The physician also acknowledged that most of those residents transferred to hospital were not eating and drinking, and that they were identified as some of the sickest residents in the home.

During an interview, William Osler Director (WOD) #104, stated that the home's management team attended a virtual webcast meeting on May 4, 2020, during which support was offered to the LTC home. The WOD verified that the situation in the home was escalated by one of their own staff members who had visited to support the home and identified and reported staffing and supply shortage, as well as infection prevention and control and care concerns. WOD #104 stated that the home did not reach out to their community partners for support. However, once they were alerted about the situation in the home, the hospital sent a team of physicians and NPs to the home to assess and support residents care needs and update their families. WOD #104 verified that on June 4, 2020, the MLTC announced a voluntary management order for William Osler Hospital to assume management of the home to develop a management and recovery plan for the next 90 days. After which, they

would implement a plan to transition the home back to the management team and the licensee. They also verified that the Canadian Armed Forces were onsite to augment the staffing and support resident care in the home. The WOD verified that they created a 'prototype' or an expanded Daily Nursing Staff Schedule which analyzed the daily schedule to clearly identify the following information: unit name, shift, unit census, RNs on duty, RN to resident ratio, RPNs on duty, RPN to resident ratio, PSWs on duty, PSW to resident ratio, number of sick RN/RPNs and No Show, number of sick PSWs and No Show. As per the WOD, this was the first time they were able to accurately capture the staff to resident ratios and identify scheduling issues such as which unit was short staff or required more staff because of an increase in infection positive residents, sick calls, no-show, novice versus expert staff on the unit; which unit had a short shift staff working therefore adjustments and transfer of staff required when that staff leave the unit, etc. Identification of these variables would affect the care and support residents required on the units and therefore, the number and mix of staffing required.

During an interview, the home's DOC verified that they were collaborating with the licensee to work on a staffing plan for potential staffing losses towards the end of an identified month. The DOC stated that there was a corporate memo with directions that staff bring a change of clothing to change before leaving the home. That was around the time when staffing levels started to drop, with staff citing child care support issues. That information was shared with their head office at the management meeting. The DOC also verified the critical staffing shortage experienced by the home during an identified week-end; and that they heard from staff that some of them had to work alone with one PSW on some units. The DOC described times when nurse manager, the DOC and ED had to step in and provide direct resident care. The DOC stated that they usually took care of the scheduling along with the scheduling team, and acknowledged that the previous schedule did not identify staffing 'no shows', short shifts and number of residents current on each unit; therefore, did not support movement and re-assignment of staff to units which were short staff, or more acute based on real time numbers. They acknowledged that since WOD#104 developed a prototype staff schedule, the team was now taking into account the number of staff available to work each shift, the census on each unit, resident acuity on each home unit, and continuity of care provided by consistent staff on each home unit.

Therefore, the home failed to ensure that the staffing plan provided for a staffing mix

that was consistent with residents' assessed care and safety needs.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 3 as it was related to the whole home. The home had a level 2 history as there were previous non-compliance to a different subsection. (535)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Oct 26, 2020(A2)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

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**Order # / No d'ordre:** 010

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 229. (5) The licensee shall ensure that on every shift,
(a) symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and
(b) the symptoms are recorded and that immediate action is taken as required.
O. Reg. 79/10, s. 229 (5).

**Order / Ordre :**

The licensee must be compliant with s. 229. (5) of the O. Reg 79/10.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that on every shift, symptoms indicating the presence of infection in residents are monitored in accordance with evidence-based practices. This plan must include:

1. The development of a written procedure or guideline to be implemented for the monitoring of residents for the presence of infection. This written procedure must include, but is not limited to:
-When residents should be monitored for signs and symptoms of infection;
-Who is responsible for monitoring residents for signs and symptoms of infection on each shift;
-What assessments must be conducted for residents exhibiting signs and symptoms of infection. The assessments must be based on evidence-based practices for the specific infection the resident is observed to have (i.e. pneumonia, COVID-19, wound infection).

A description of training and education that will be provided to all registered staff on the written procedure or guideline mentioned above. Indicate who will be responsible for providing education, and the dates this education will occur. This written procedure or guideline must be readily accessible at all nursing stations.

Please submit the written plan for achieving compliance for inspection #2020_780699_0014 to Praveena Sittampalam, LTC Homes Inspector, MLTC, by email to TorontoSAO.MOH@ontario.ca by September 25, 2020. Please ensure that the submitted written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. The licensee has failed to ensure staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice.

Record review of the home's IPAC surveillance records and the York Region Respiratory Outbreak Line Listing indicated that the document to be completed by registered staff on each resident care unit was sometimes incomplete, and did not

consistently capture residents' symptoms including their temperature.

During an interview, Support DOC (SDOC) #117 stated that they started working in the home on June 2, 2020, to support IPAC surveillance and accurate line listing of residents. They were responsible for sending the line list to York Regional Public Health (YRPH) daily. When they arrived and reviewed the home's infection surveillance records, it was difficult to figure out how to move forward because of the lack of consistent information recorded on the line listing document. They created a new excel document for ease of use by staff. The SDOC stated that they posted the updated spreadsheet document daily on each resident care unit so that staff could access that information. The posting of residents line listing on all units was not happening prior to their arrival in the home.

According to the SDOC, to promote efficiency, they informed the team to stop using the internal surveillance record and to only use the York Region Respiratory Outbreak Line-Listing document to track symptoms in infection positive residents so that it could be submitted to public health when completed instead of having to transfer the information.

On May 31, 2020, the Medical Officer of Health from the Regional Municipality of York issued an order under Section 29.2 (1) of the Health Protection and Promotion Act, to the home to take the following action related to active surveillance: Provide accurate and timely information requested by York Regional Public Health, William Osler Health System, Public Health Ontario, and the Central LHIN West Local Health Integrated Network regarding any and all aspects if the outbreak in the institution. This includes but is not limited to providing York Regional Public Health no later than 10 a.m. each day, the name and requested details for staff and residents symptomatic for infection and the names and requested details for asymptomatic residents and staff who have tested positive for infection.

Therefore, the home has failed to ensure staff monitored symptoms of infection in residents on every shift in accordance with evidence-based practices and, if there were none, in accordance with prevailing practice.

The severity of this issue was determined to be a level 3 as there was actual harm/risk to the residents. The scope of the issue was a level 1 as it was related to the whole home. The home had a level 2 history as there were previous non-

compliance to a different subsection.
(535)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Nov 13, 2020(A2)

## 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

## REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

## Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L.O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

## 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

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## RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

## Order(s) of the Inspector

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Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON  M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

**Issued on this  22nd  day of January, 2021 (A4)**

**Signature of Inspector /**
**Signature de l’inspecteur :**

**Name of Inspector /**
**Nom de l’inspecteur :** Amended by PRAVEENA SITTAMPALAM (699) - (A4)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

## Order(s) of the Inspector

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**Service Area Office / Bureau régional de services :** Toronto Service Area Office