Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Apr 11, 2019	2019_670571_0003	005232-18, 008750-18, 019941-18, 021207-18, 032775-18, 032818-18, 000450-19, 001033-19, 005707-19	Complaint

Licensee/Titulaire de permis

CVH (No. 6) GP Inc. as general partner of CVH (No. 6) LP
766 Hespeler Road, Suite 301 c/o Southbridge Care Homes CAMBRIDGE ON N3H 5L8

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

Orchard Villa
1955 Valley Farm Road PICKERING ON L1V 3R6

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

PATRICIA MATA (571), SARAH GILLIS (623)

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): February 19-22, 25-March 1, March 4-8, 2019

The following complaint intake logs were inspected:
005232-18; 008750-18; 032775-18; 032818-18 related to resident care
019941-18 related to personal care, maintenance and supplies
021207-18 related to supplies and staffing
000450-19 related to resident abuse
001033-19 related to safe lift and transfers
005707-19 related to resident change in condition

During the course of the inspection, the inspector(s) spoke with the Executive Director, Director of Care (DOC), Resident Care Area Managers (RCAM), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Environmental Services Supervisor (ESS), Housekeeper and Laundry Aides.

The following Inspection Protocols were used during this inspection:
Accommodation Services - Laundry
Accommodation Services - Maintenance
Falls Prevention
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **3 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other.

Related to a complaint:

A complaint was received by the Director from the Action Line, on a specified date. The complainant alleged resident #010 had been neglected. The SDM voiced concerns to the nursing staff about a change in condition for resident #010, and requested a specified intervention. The complainant indicated that the requested specified intervention was not done for a specified time period.

A review of the resident's clinical medical records by Inspector #571 indicated that resident #010 had a history of a specific medical condition.

A review of the physician orders by Inspector #571 for a specified period indicated the following:
-on a specified date: Physician ordered an identified medical intervention; a number of days later the Nurse Practitioner (NP) re-ordered the intervention as the original order had not been implemented and on the same day the Physician ordered a specified medication; a number of days later, the Physician ordered additional medication to treat the identified medical condition; a number of days later, the Physician ordered that the resident be transferred to the hospital.

A review of the progress notes indicated that the Physician was not contacted for a number of days after the SDM brought their concerns forward to RPN #133. The initial

Physician's order was not carried out until a number of days later when the Physician had to rewrite the order. The resident's condition continued to deteriorate.

In separate interviews with Inspector #571, RPN #122, #123 and #137 indicated that they could not recall the events related to this complaint.

RPN #122 indicated that their normal practice would be to make a note in the Physician's book if a family requested an order be obtained. If the matter was urgent they would call the Physician during the day or the on-call Physician after hours. If an order was not implemented on their shift, RPN #122 would report it to the oncoming nurse verbally and write it in the 24 hour unit report.

RPN #123 indicated that their normal practice would be to make a note in the Physician's book if a family requested an order be obtained if the Physician was coming in to the home within the next few days. If the matter was urgent they would call the Physician during the day or the on-call Physician after hours or the NP. RPN #123 indicated that if they were unable to implement the order, they would call the Physician or NP. RPN #123 was asked by Inspector #571 how many days they would they try to implement an order before they called the Physician and they indicated that if the resident was symptomatic they would call right away. The RPN indicated that if an order needed to be implemented and was not completed on their shift, then it would be communicated to the next shift using the nurses 24 hour unit report or in the progress notes or verbally during shift report. The RPN indicate that their practice was to read the progress notes from the previous shift.

RPN #137 indicated that if a family member requested an order be obtained from the Physician, they would assess the resident and call the Physician if the matter was urgent. If the matter was not urgent they would write it in the Physician communication book and document a progress note so that staff would continue to monitor and call the Physician if there are any change in condition for the resident. If the Physician was not coming in for a number of days the RPN would either call the Physician or ask another Physician who is in the building to see the resident. RPN #137 indicated that if they were unable to implement a Physician order they might try for a number of days but if the resident's condition was deteriorating than they would call the Physician to inform them. RPN #137 indicated the need for an order to be implemented if not done on their shift was to be communicated by writing it in the 24 hour unit report and the progress notes and via the verbal shift report. RPN #137 may also inform the charge RN. The RPN indicated that when they come on shift they would normally receive verbal report from the nurse on the

previous shift and read the 24 hour unit report where the previous nurse had given a summary of significant points. They would also run the report from Point Click Care (PCC) for the last 24hrs. In addition, the chart would remain flagged on the cart if the order has not been implemented because the nurse is not supposed to sign the Physician's order as processed until the order was implemented. The flagged charts are normally kept on their side in the cart and the charts without orders that do not need to be checked are kept in an upright position on the cart. RPN #137 indicated that they check the charts that are flagged every shift but sometimes the chart is backwards or the flag is accidentally pushed back in so they may not see the flag and they do not always check those charts for unprocessed orders. When asked by Inspector #571 if there was any other way a nurse would know that a Physician order still needed to be implemented, the RPN described a different specific intervention that is utilized so that the nurses would know the order had not been implemented yet.

The concerns brought forward to the nursing staff by the SDM for resident #010 were not communicated to the Physician by the nursing staff in a timely matter when the resident's condition deteriorated. When a specific order was received, there was no indication this had been communicated between the shifts, and when the order was not implemented there was no indication that there was collaboration from shift to shift. There was no indication that nursing staff communicated with the Physician, to inform them that the order had not been implemented despite the resident's condition deteriorating. A number of days after the Physician ordered a specified medical intervention it had not been implemented. Although resident #010 was treated starting a number of days after the SDM first voiced their concern to the registered nursing staff and a number of days after the Physician originally wrote the order, the resident required transfer to the hospital.

The licensee failed to ensure that staff and others involved in the different aspects of care for resident #010 collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other. [s. 6. (4) (a)]

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 with ensuring that staff and others involved in the different aspects of resident care collaborate with each other in the assessment of the resident so that assessments are integrated, consistent with and complement each other, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff use safe transferring and positioning devices or techniques when assisting residents.

Related to a complaint:

A complaint was submitted to the Director on a specified date that included a concern about staff completing improper transfers.

On a specified date, Inspector #571 observed resident #003 in the hallway. Inspector #571 observed PSW #106 assist resident #003 into their room. Shortly afterwards, PSW #106 exited resident #003's room alone. Inspector #571 immediately observed the resident lying in bed.

A review of resident #003's current care plan indicated that the resident required two staff for transfers.

In an interview with Inspector #571, PSW #106 acknowledged that they transferred resident #003 to bed by themselves. PSW #106 indicated that they knew the resident required two staff for transfers but that they were trained by co-workers to transfer the resident with one person. PSW #106 indicated that the plan of care instructs that the

resident was to be transferred with two staff.

In an interview with Inspector #571 on February 28, 2019, the DOC indicated that it was their expectation that two staff transfer resident #003 as per the resident's plan of care.

Therefore, the licensee has failed to ensure that staff use safe transferring techniques when transferring resident # 003. [s. 36.]

2. Related to a Critical Incident:

A Critical Incident (CI) was submitted to the Director for an incident occurring on a specified date. The critical incident indicated that PSW #113 was transferring resident #007 when the resident slid to the floor.

A review of the licensee's policy LP-01-01-02 Last Updated August 2017 included the following: "Two trained staff are required at all times when performing" a specified lifting technique. "All breaches of the policy or procedure will result in an investigation, and may result in progressive discipline up to and including terminations."

In an interview with Inspector #571, PSW #113 indicated that they did transfer the resident by themselves. PSW #113 acknowledged that the policy indicates that two staff members are to be present when using the specified transfer technique.

In an interview with Inspector #571 on February 28, 2019, the DOC indicated that their expectation is that two staff were to be present when the specified transfer technique was used for resident transfers. This incident was investigated and action taken.

Therefore, the licensee has failed to ensure that staff use safe transferring techniques when transferring resident #007. [s. 36.]

3. Related to Resident #014:

A review of the licensee's investigation notes for an incident related to a separate log involving resident #014 indicated that PSW #145 had used an improper transfer technique to transfer the resident on a specified date.

In an interview with Inspector 571, PSW #145 indicated that they did not use the transfer technique as specified in the resident's plan of care.

A review of the "Safe Lift and Transfer Assessment - V2" from a specified date, indicated that a specified transfer technique was to be used for resident #014 and that a transfer logo was displayed for staff reference.

Therefore, the licensee has failed to ensure that staff use safe transferring techniques when transferring resident #014. [s. 36.]

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 for ensuring that staff use safe transferring techniques when assisting residents, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents.

Related to three complaint logs.

Complaint:
An anonymous complaint was received on a specified date, via the Action Line indicating that there are not enough towels to provide care to the residents and not enough linens to change the beds. The complainant indicated that laundry is getting done, there is just

not enough to go around.

Complaint:
An anonymous complaint was received via the Action Line on a specified, indicating that the home is in short supply of soaker pads, sheets and bath towels. The complainant indicated that this issue has been brought to the attention of the home's Administrator, but the issue has not been resolved. The management team was aware of the issue.

Complaint:
An anonymous complaint was received on a specified date, by the Action line, indicating that the home does not have enough linens for all of the units and that the home is no longer using soaker pads.

Observation in the home by Inspector #623 on a specified date identified the following:

On an identified resident home area- all resident beds were made and there was a complete change of linen. Most bathrooms did not have face cloths or towels hanging on the towel rack. 10 beds had clean face cloths and towels folded on beds that were made. Each linen cart had approximately 10 face cloths, two towels and two sets of sheets. The linen cupboard was locked at the time and staff were not available to unlock the cupboard. In the tub room there was a bin with incontinent products of all sizes.

On an identified resident home area- all but one resident beds were made with a complete change of linens. The one bed was stripped to the mattress. There were no face cloths or towels in any of the resident's bathrooms. There were six resident rooms with clean face cloths and towels folded on the bed. The linen cart had two sets of sheets available, five face cloths and one towel. The Spa room had no bath towels, but there were 10 face cloths, five hand towels and four sheets. There was a large Rubbermaid bin on the floor that was filled with a variety of continence products.

On an identified resident home area- all resident beds were made and there was a complete change of linen. Most resident bathrooms did not have face cloths or towels in them. Six resident rooms had clean towels and face cloths folded on the bed. The linen carts did not have any sheets, each had four face cloths and no hand towels. The Spa room was occupied.

On an identified resident home area- there were two residents beds not made (unclear if they were vacant beds, no names identified on the door). All other beds were made and

there was a complete change of linen. One linen cart was located in entry to a resident's room. The cart had no sheets, two face cloths and no towels. There were no towels located in the resident bathrooms. Four resident rooms had a folded face cloth and towel on their bed. The Spa room did not have any bath towels. There was a bin with a variety of continence products available.

Review of the Inventory count sheet – Bedding, linen and towel - for an identified period, indicated the following linens were available in the home for 233 residents:
Wash cloths – 580
Hand towel – 448
Bath towel – 54
Flat sheet – 220
Fitted sheet – 240

A second inventory count sheet – Housekeeping supplies – for an identified area, indicated the following linens were available in the home for 233 residents:
Towels and Face cloths – 580
Bath towel – 54
Hand towel – 72
Face cloths – 120
Peri cloths – 0
Fitted sheets – 36
Flat sheets – 42

Review of the Extendicare Policy HKLD 06-01-01 Appendix 2 indicated the following:

Extendicare has recommended linen inventory standards that take into account a 2.5 day supply of quotas. (Orchard Villa has 233 residents)

Recommended guidelines:
Top Sheets – 2.0 per bed
Bottom Sheets – 2.0 per bed
Face Cloth (personal care) – 4.5 per bed
Hand Towel (personal care) – 4.5 per bed
Bath Towel – 2-3 per scheduled bath per day x 2.5 days' supply

On two specified dates, Inspector #623 completed a tour of all resident homes areas to observe linen supplies. All beds were made and there was a complete change of linen.

The linen carts had a small supply of linens available. There were bath towels present in all spa rooms. The resident's bathrooms had a hand towel and a face cloth on the towel bar in each bathroom. There was no shortage of linens identified.

On a specified date, Inspector #623 completed observations on an identified resident home area home area that revealed there were four beds stripped to the mattress and there was no linen available to make the beds. No towels or facecloths in any resident rooms. There were no towels in the Spa room. The linen cupboard contained bedspreads, blankets, and one flat sheet.

Review of the Extendicare Policy HKLD 06-01-01 Appendix 2 indicated the following:

Extendicare has recommended linen inventory standards that take into account a 2.5 day supply of quotas. (Orchard Villa has 233 residents)

Recommended guidelines:
Top Sheets – 2.0 per bed
Bottom Sheets – 2.0 per bed
Face Cloth (personal care) – 4.5 per bed
Hand Towel (personal care) – 4.5 per bed
Bath Towel – 2-3 per scheduled bath per day x 2.5 days' supply

On a specified date, during an interview with Inspector #623, PSW #103 indicated that on most days they are short linens and continent supplies including incontinent products and wipes. The PSW indicated that this week, there has been more than enough supplies of everything. The PSW indicated that if they run out of continence supplies on the unit, they can get more but have to request it from the RN supervisor. The PSW indicated that if there is a staff shortage in the laundry department than there is no linen in the morning. The day linen person arrives and would have to wash and dry the quota for the units. This could take until about 10 am before supplies are available. The PSW indicated that this happens one to two times a week. If there is a shortage of towels, then residents might not get washed properly for morning care and showers will not be given. The PSW indicated that when the cart does arrive in the unit, they try to find enough linen to get their work done. The PSW indicated that they report shortages to management but nothing seems to happen about it.

On a specified date, during an interview with Inspector #623, PSW #111 indicated that there was an adequate supply of linens and towels that day. They also indicated that

they have access to continence supplies including wipes, and that they do not run out of continence supplies. The PSW indicated that they might need to ask the RN for more, but they are always available.

On a specified date, during an interview with Inspector #623, PSW #137 indicated four beds were unmade because there were no linens available this morning. PSW #137 indicated that there was a staff shortage in laundry and at 0700 hours, there were no linens for the day shifts. The PSW indicated that they did not have face cloths, hand towels, bath towels, or sheets. The PSW indicated that the DOC provided them with wet and dry wipes so that morning care could be completed and at 1000 hours, the laundry was able to provide six bath towels for each unit so that residents could receive their bath. There were nine residents scheduled to receive a bath or shower that day. A small quantity of face cloths, hand towels and sheets were also provided to the units so that some of the resident's beds could be made. The PSW indicated that not every resident required linens to be changed daily. The PSW indicated that this happens often, where they are short of linen supplies, but could not recall when the last time was. The PSW indicated that if baths cannot be completed because they do not have enough towels, then they must report this to the RPN so that they can pass this information on to Management. The RPN indicated that baths are supposed to be made up the following shift or the following day, but someone else is scheduled to complete this task.

On a specified date, during an interview with Inspector #623, RPN #144 indicated that this morning they were short linens and towels. The RPN indicated that when the day shift started, there was no linen cart available for the an identified resident home area. The RPN indicated that they were informed there was a staff shortage in laundry, therefore the laundry did not get washed and would not be available until the day laundry aide could get it washed and dried. The RPN indicated that this happens frequently. RPN #144 indicated that today and on another identified morning, the DOC provided wet and dry wipes so that the resident's morning care could be provided. The RPN indicated that any residents who were scheduled for a bath or shower would have to wait until the towels were available. The RPN indicated that if a resident does not receive a bath because there were not enough towels, then the DOC must be informed so that the bath could be rescheduled. The RPN indicated that they are also expected to document that the bath was missed and notify the SDM.

On a specified date, during an interview with Inspector #623, Laundry Aide (LA) #141 indicated that they worked on the day shift. The night shift is responsible for washing all the towels, sheets and face cloths, so that they are ready for the morning. The laundry

aide indicated that when they arrive on shift, they are responsible to deliver the clean linens to the resident home areas units. LA #141 indicated that morning there were no linens and towels washed and ready for delivery because they were short staffed on a previous shift. LA #141 indicated that this happens often, and when it does, the nursing staff do not have the supplies they need for morning care. The LA indicated that if a laundry staff were to call in sick after hours, there is no one there to take the call and cover the shift.

On a specified date, during an interview with Inspector #623, Housekeeper #142 indicated that when they are behind in the laundry the housekeeper is pulled from their job to help fold laundry so that it can be delivered to the resident home areas. The housekeeper indicated that this happens every couple of weeks, but this week it had happened two times. The housekeeper indicated that when they are asked to assist with the laundry, there is no one completing their housekeeping work.

On a specified date, during an interview with Inspector #623, the DOC indicated that the Environmental Services Supervisor (ESS) and the Programs Manager are collaboratively overseeing the Environmental Services in the home while there is a vacancy for the Environmental Services Manager (ESM) role. The DOC indicated that there was an issue that day with staffing shortage in the laundry and there was also an issue on another identified day. The DOC indicated that they have discussed with the ED the impact this has on nursing and the need for a staffing back up plan for laundry when the night shift calls in sick. The DOC indicated that today and also another date, the PSW staff did not have towels, facecloths, and bath towels for morning care because there was no none in laundry to wash the supplies and deliver them to the units for morning due to staff shortage. The DOC indicated that this has happened twice that week, but had happened at least once every three weeks. The DOC indicated that that morning and on another specified date they distributed wet wipes and dry wipes so that morning care could be provided to the resident's. The DOC indicated that on a specified date all showers and baths were given, the DOC would be monitoring to ensure that all showers and baths were given and if necessary, they would schedule a PSW to make up the baths if any were missed.

On a specified date, during an interview with Inspector #623, the ESS indicated that at this time they are assisting with the management of Environmental Services, in the absences of a manager. The ESS indicated that together with the Resident Program Manager, they cover the department. The ESS indicated that they were short staff that day. The ESS indicated that when the laundry staff call in sick, they call and leave a

message. If it is after hours, no one will get that message until the next day. This is what happened the previous evening causing the laundry to be incomplete for morning. The ESS indicated that the LA who works on the night shift was responsible for washing all of the towels, face cloths, hand towels and sheets so that they were clean and ready to be delivered to the units early in the morning. When this shift is left unfilled, it causes a backlog in the laundry. There is no emergency or pandemic supply of linens to draw from. The ESS indicated that have an ongoing problem with staff shortages. The ESS indicated that there is no extra linens, towel or face cloths, laundry was done just in time, and there was no buffer for when the system failed. The ESS indicated that they believe that there was enough linens, but staff were hoarding them so it appeared that they were short. The ESS indicated that together with the Executive Director (ED), they were working on a plan going forward so this does not happen again.

During an interview with Inspector #623, the ED indicated that they were aware that when there was a staff shortage in the laundry department, this left a gap in the delivery of supplies to the resident home areas. The ED indicated in an identified time period , staff had complained about the shortage of laundry supplies, and the Regional Director (RD) was looking into the available supplies with the former ESM. The ED indicated that there was an email inquiry by the RD to the ESM. At that time the RD asked if there was enough linen for a 24 hour supply. The RD also requested a count of the linen supplies. The response from the ESM was that they depend on the laundry processing to keep up the supply and that they believed there was more than 24 hours' worth of linen in the cycle each day. The ESM indicated that they release additional supplies weekly to compensate for shortages and have increased the supplies in the recent months. The ESM also indicated in the email that they would provide a projected daily linen requirement as they move towards a 24 hour cart system and identified that they would need to ramp up inventory to three times the quantity in order to compensate for this. The ED indicated that at the end of a specified time period, they provided the RD with the total linen inventory count. The ED indicated that they were uncertain of what the number on the count sheets represented or why there were two different lists. The ED did not know if the two lists should be added together to create the final count of available linens in the home. The ED indicated that they were unable to provide any further information regarding the outcome of the RD's inquiry related to the linen supply. The ED indicated that there was a gap in the call in process to cover unexpected absences in the laundry department. The ED indicated that it appears by looking at the inventory count sheets, that they do not have the required amount of linens for the home, as indicated in the Extendicare Policy HKLD 06-01-01 Appendix 2 – Linen Inventory Standards Guidelines (September 2013). The ED indicated that the inventory count sheets were completed by

the former ESM and were submitted to Head Office for the end of the year. The ED was also not aware of any additional linen supplies in storage that could be put into circulation at this time. The ED indicated that they are currently in discussions with head office, to move to a 24-hour delivery cart system for linens but this has not been implemented yet.

The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents. [s. 89. (1) (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 for ensuring that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there is a sufficient supply of clean linens, face cloths and bath towels always available in the home for use by the residents., to be implemented voluntarily.

Issued on this 29th day of April, 2019

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

Original report signed by the inspector.