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

Sudbury Service Area Office
159 Cedar Street Suite 403
SUDBURY ON P3E 6A5
Telephone: (705) 564-3130
Facsimile: (705) 564-3133

Bureau régional de services de Sudbury
159, rue Cedar Bureau 403
SUDBURY ON P3E 6A5
Téléphone: (705) 564-3130
Télécopieur: (705) 564-3133

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
Jun 23, 2020	2020_746692_0006 (A1)	021863-19, 021864-19, 021865-19	Follow up

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Tri-Town
143 Bruce Street P.O. Box 999 HAILEYBURY ON P0J 1K0

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

Amended by SHANNON RUSSELL (692) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has been granted an extension to the compliance due date in relation to the Emergency Management and Civil Protection Act order, dated March 27, 2020.

Issued on this 23rd day of June, 2020 (A1)

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

Long-Term Care Operations Division
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3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Tri-Town
143 Bruce Street P.O. Box 999 HAILEYBURY ON P0J 1K0

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

Amended by SHANNON RUSSELL (692) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): March 2-6, 2020.

The Following intake(s) were inspected upon during this Follow Up Inspection:

-One Log, which was related to compliance order #001 that was issued during inspection #2019_669642_0019, s. 8 (3) of the Long-Term Care Homes Act (LTCHA), 2007, specific to the licensee ensuring that there was at least one registered staff nurse on duty and present in the home at all times;

-One Log, which was related to compliance order #002 that was issued during inspection #2019_669642_0019, r. 31 (2) of the LTCHA, 2007, specific to the licensee ensuring there was a written staffing plan for the nursing and personal support services; and,

-One Log, which was related to compliance order #003 that was issued during inspection #2019_669642_0019, s. 8 (1) of the LTCHA, 2007, specific to the licensee ensuring there was an organized nursing and personal support services that met the assessed needs of the residents.

A Complaint Inspection #2020_746692_0007 was conducted concurrently with this inspection.

Please note: A Compliance Order related to s. 8 (3) was also identified in a concurrent inspection, Complaint inspection #2020_746692_0007, was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator/Director of Care (DOC), Office Manager, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

The Inspector(s) also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions and resident to resident interactions, reviewed relevant health care records, as well as licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:
Sufficient Staffing

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

- **1 WN(s)**
- **0 VPC(s)**
- **1 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 31. (2)	CO #002	2019_669642_0019	692
LTCHA, 2007 S.O. 2007, c.8 s. 8. (1)	CO #003	2019_669642_0019	692

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

Compliance order #001 was served on November 1, 2019, from inspection report

#2019_669642_0019, related to section 8 subsection 3 of the Long-Term Care Home's Act (LTCHA) 2007, and had a compliance due date of December 13, 2019. The compliance order stated: "The licensee must be compliant with s. 8 (3) of the LTCHA. Specifically, the licensee must ensure there is at least one registered staff 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".

A complaint had been submitted to the Director on an identified date, regarding resident care concerns, including that there had not been a Registered Nurse (RN) on duty and in the home at all times.

Inspector #692 requested the RNs schedule and was provided with a document titled, "Rotation Registered Staff". The document contained a certain number of months of the registered staff schedule for the period from a specific month and day in 2019, to another specific month and day in 2020. The Inspector reviewed the document, and identified that a RN had not been on duty and present in the home at all times during this period.

The Inspector interviewed the Office Manager, who completed the registered staff schedule, and identified the dates and shifts that a RN had not worked in the home. The Office Manager indicated that they had not scheduled a RN on site in the home 24 hours a day, due to the home being short RNs, and that they had been filling the RN shifts with Registered Practical Nurses (RPNs) and a RN on call. The Administrator/Director of Care (DOC) had also been covering as the RN in the home. The Office Manager identified that the home had three RN shifts per day (day, evening, and night shifts); and over the period reviewed, there had been RN shifts that had not been filled.

The Office Manager identified the dates and the shifts that the home had not had a RN on duty and in the home, which included:
-a 30 day review of the schedule, indicated that 35.6 percent of the RN shifts were not covered, which included; day, evening, and night shifts;
-another 30 day review of the schedule, indicated that 7 percent of the RN shifts were not covered, which included; day, evening, and night shifts; and
-a review of another 17 day review of the schedule, indicated that 6.9 percent of the RN shifts were not covered, which included; day, evening, and night shifts.

Inspector #692 conducted observations of the home for a five day period, and

identified that there was not a RN working in the home on all five day shifts.

In an interview with the Office Manager, they indicated to the Inspector that there was not a RN on duty for the day shifts that had been identified by the Inspector, and there was not a RN on duty for the evening or night shifts on an identified date during this period. The Office Manager identified that these shifts were covered with RPNs with the Administrator/DOC available as the RN.

In separate interviews with RPNs #102 and #103, and RN #104, they all indicated that the home had been working without a RN on duty and present in the home at all times. They all identified that when there had not been a RN in the home, the RPNs would be in charge and would go to, or call the Administrator/DOC. RPN #102 identified that they were in charge on the day shift , and that RPN #103 was the charge nurse for the evening shift on the identified date, with the Administrator/DOC as the RN.

Inspector #692 interviewed the Administrator/DOC, who identified that they were aware that they were to have a RN 24/7; however, they had not been able to have a RN on duty and present in the home, and that it had worsened in the last month. They indicated that they have been filling the RN shifts with RPNs, and with them on call as the RN, due to the home having been short RNs to cover the shifts. The Administrator/DOC indicated that the home has not been staffed with a RN 24 hours per day, and they should have been. [s. 8. (3)]

Additional Required Actions:

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

(A1)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 001

Issued on this 23rd day of June, 2020 (A1)

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 SHANNON RUSSELL (692) - (A1)
Inspection No. / No de l'inspection :	2020_746692_0006 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	021863-19, 021864-19, 021865-19 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 23, 2020(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Tri-Town 143 Bruce Street, P.O. Box 999, HAILEYBURY, ON, P0J-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Johnson

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 Extendicare (Canada) Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2019_669642_0019, CO #001;

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 Long Term Care Homes Act (LTCHA), 2007.

Specifically, the licensee shall prepare, submit and implement a plan to ensure that there is 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.

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

1. How the licensee will recruit and retain registered nurses; and,

2. How the licensee will ensure that there is a registered nurse on duty and present in the home at all times.

Please submit the written plan, by quoting inspection number 2020_746692_0007 and Inspector Shannon Russell by email to SudburySAO.moh@ontario.ca by June 5, 2020.

Please ensure that the submitted plan written does not contain any PI/PHI.

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 at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff of the home was on duty and present in the home at all times.

Compliance order #001 was served on November 1, 2019, from inspection report #2019_669642_0019, related to section 8 subsection 3 of the Long-Term Care Home's Act (LTCHA) 2007, and had a compliance due date of December 13, 2019. The compliance order stated: "The licensee must be compliant with s. 8 (3) of the LTCHA. Specifically, the licensee must ensure there is at least one registered staff 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".

A complaint had been submitted to the Director on an identified date, regarding resident care concerns, including that there had not been a Registered Nurse (RN) on duty and in the home at all times.

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The Inspector interviewed the Office Manager, who completed the registered staff schedule, and identified the dates and shifts that a RN had not worked in the home. The Office Manager indicated that they had not scheduled a RN on site in the home 24 hours a day, due to the home being short RNs, and that they had been filling the RN shifts with Registered Practical Nurses (RPNs) and a RN on call. The Administrator/Director of Care (DOC) had also been covering as the RN in the home. The Office Manager identified that the home had three RN shifts per day (day, evening, and night shifts); and over the period reviewed, there had been RN shifts that had not been filled.

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not covered, which included; day, evening, and night shifts;
-another 30 day review of the schedule, indicated that 7 percent of the RN shifts were not covered, which included; day, evening, and night shifts; and
-a review of another 17 day review of the schedule, indicated that 6.9 percent of the RN shifts were not covered, which included; day, evening, and night shifts.

Inspector #692 conducted observations of the home for a five day period, and identified that there was not a RN working in the home on all five day shifts.

In an interview with the Office Manager, they indicated to the Inspector that there was not a RN on duty for the day shifts that had been identified by the Inspector, and there was not a RN on duty for the evening or night shifts on an identified date during this period. The Office Manager identified that these shifts were covered with RPNs with the Administrator/DOC available as the RN.

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The severity of this issue was determined to be a level three, as actual risk to residents of the home. The scope of issues was a level two, which identified as a pattern. The home had a level four compliance history, as despite Ministry of Long-Term Care (MLTC) action, non compliance continues with the original area of non-compliance which included;
-one written notification (WN) issued July 06, 2017 (#2017_657681_0001);

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

-one voluntary plan of correction (VPC) issued July 06, 2017 (#2017_657681-0001), and;
-compliance order #001 issued November 1, 2019, with a compliance due date of December 13, 2019 (#2019_669642_0019).
(692)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Oct 31, 2020(A1)

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:

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.

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

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

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 23rd day of June, 2020 (A1)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SHANNON RUSSELL (692) - (A1)

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

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