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**

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## Amended Public Copy/Copie modifiée du rapport public

| Report Date(s)/ Date(s) du Rapport | Inspection No/ No de l'inspection | Log #/ No de registre | Type of Inspection / Genre d'inspection |
|---|---|---|---|
| Jan 27, 2020 | 2019_773155_0007 (A4) | 024923-18, 027747-18, 027750-18, 027753-18, 027757-18, 027758-18, 027761-18, 027764-18, 027765-18, 027767-18, 029896-18, 033380-18, 033400-18, 002919-19, 003499-19, 003666-19, 003948-19, 005805-19, 006253-19, 007064-19 | Follow up |

### Licensee/Titulaire de permis

2063412 Ontario Limited as General Partner of 2063412 Investment LP
302 Town Centre Blvd. Suite 300 MARKHAM ON L3R 0E8

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

Creedan Valley Care Community
143 Mary Street CREEMORE ON L0M 1G0

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

Amended by SHARON PERRY (155) - (A4)

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

**Compliance order #006 compliance due date extended from January 31, 2020 to February 14, 2020.**

**Issued on this 27th day of January, 2020 (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*

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

Amended by SHARON PERRY (155) - (A4)

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## 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 5, 6, 7, 8, 11, 12, 13, 14, 15, 19, 20, 21, 22, 25, 26, 27, 28 and 29, 2019**

**The following intakes were completed within this follow-up inspection:**

**Log # 027747-18 - Follow-up to compliance order #001, inspection # 2018_742527_0012, related to having a registered nurse on duty and present at all times;**

**Log # 027757-18 - Follow-up to compliance order #002, inspection # 2018_742527_0012, related to equipment being kept clean and sanitary;**

**Log # 027758-18 - Follow-up to compliance order #003, inspection # 2018_742527_0012, related to staff receiving orientation prior to performing their duties;**

**Log # 027761-18 - Follow-up to compliance order #004, inspection # 2018_742527_0012, related to staffing plan that provides for staffing mix that is consistent with residents' needs;**

**Log # 027764-18 - Follow-up to compliance order #005, inspection # 2018_742527_0012, related to bathing;**

**Log # 027765-18 - Follow-up to compliance order #006, inspection # 2018_742527_0012, related to safe positing of residents while eating and drinking;**

**Log # 027767-18 - Follow-up to compliance order #007, inspection # 2018_742527_0012, related to record being kept of staff members qualifications;**

**Log # 027750-18 - Follow-up to compliance order #001, inspection # 2018_742527_0013, related to protecting residents from abuse;**

**Log # 027753-18 - Follow-up to compliance order #002, inspection # 2018_742527_0013, related to responsive behaviours;**

**Log # 029896-18 and Log #024923-18 related to complaints regarding alleged improper/incompetent treatment of a resident;**

**Log # 033380-18 regarding alleged neglect of a resident;**

**Log # 033400-18 / Log 003948-18 / and Log 003666-19 related to an injury that resulted in the transfer to hospital with significant change in status;**

**Log 002919-19 / Log 005805-19 / Log 006253-19 / and Log 007064-19 regarding alleged abuse/neglect of residents; and**

**Log 003499-19 regarding reporting and complaints.**

**During the course of the inspection, the inspector(s) spoke with Executive Director, Director of Care, Assistant Director of Care, Assistant Director of Care/Resident Assessment Instrument (RAI) Coordinator, Office Manager, Scheduling Coordinator, Medical Director, Corporate Clinical Care Support, Recreation Director, Director of Dietary Services, Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Care Support Assistants, Housekeeping staff, family members and residents.**

**During this inspection, inspector(s) toured resident care areas; observed meal service; reviewed relevant clinical records, policies and procedures, meeting minutes, schedules, employee files, education records, home's investigation notes; observed the provision of resident care, resident-staff interactions, and observed the general maintenance, cleanliness, safety and condition of the home.**

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

**Accommodation Services - Housekeeping**
**Accommodation Services - Maintenance**
**Admission and Discharge**
**Critical Incident Response**
**Dignity, Choice and Privacy**
**Falls Prevention**
**Hospitalization and Change in Condition**
**Medication**
**Nutrition and Hydration**
**Personal Support Services**
**Prevention of Abuse, Neglect and Retaliation**
**Reporting and Complaints**
**Responsive Behaviours**
**Safe and Secure Home**
**Skin and Wound Care**
**Sufficient Staffing**
**Training and Orientation**

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

- **21 WN(s)**
- **6 VPC(s)**
- **18 CO(s)**
- **1 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. 234. (1) | CO #007 | 2018_742527_0012 | 155 |
| O.Reg 79/10 s. 73. (1) | CO #006 | 2018_742527_0012 | 694 |

**NON-COMPLIANCE / NON - RESPECT DES EXIGENCES**

| Legend | Légende |
|---|---|
| WN – Written Notification<br>VPC – Voluntary Plan of Correction<br>DR – Director Referral<br>CO – Compliance Order<br>WAO – Work and Activity Order | 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. 3. Residents' Bill of Rights**

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

**s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:**
**8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the resident's right to be afforded privacy when bathing/showering was fully respected and promoted.

Resident #015 and resident #017 shared that they were bathed in the tub room that had two tubs in the room. They expressed that when they were bathed, there was another resident in the other tub at the same time. They stated that a privacy curtain was used but they could hear the other residents and any interactions that took place.

PSWs #114, #125 and #128 shared that they bathe two residents in the tub room at the same time with a privacy curtain separating the area.

The tub room was observed and it was noted that the privacy curtains in the tub room were coming off the hooks. There was also ceiling lift tracking that prevented the privacy curtains from closing. The curtains were observed on some occasions not to be fully closed and they hung leaving a gap of approximately 15 cm, on other occasions they were held together by one or two office clips.

ADOC/RAI Coordinator #103 shared that they ask residents on admission if they would mind being bathed when another resident was in the tub because on a previous inspection a resident had told an inspector that they felt like an inmate while being bathed. PSW #114 shared that after the last inspection the home stopped bathing two residents in the tub room at the same time for a short time but had resumed the practice using privacy curtains.

Resident #037 who had the cognitive ability to express their right to privacy during bathing was afforded a bath with no other residents in the tub room.

The licensee failed to ensure that the resident's right to be afforded privacy when bathing/showering was fully respected and promoted for every resident. [s. 3. (1) 8.]

***Additional Required Actions:***

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

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**WN #2: 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. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).**

**s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,**
**(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).**
**(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).**
**(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).**

**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 the care set out in the plan of care was provided to the resident as specified in the plan.

a) Resident #005 had a fall. They were assessed by registered staff and the plan of care was updated to include the use of identified devices as a fall prevention intervention.

Resident #005 was observed on three different occasions during this inspection

and only one device was in use.

PSWs #107, #108, and #113 stated that resident #005 had one device in place.

RN #109 reviewed resident #005's plan of care and acknowledged that not all of the devices were in place as specified in their plan of care.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

b) On an identified date, resident #032 was observed hanging off the edge of their bed with the bed being in the highest position. They were calling for help and their alarm was ringing. PSW #119 went in to assist the resident and lowered their bed to the floor.

The clinical records of resident #032 indicated that they were at risk for falls. They had a high-low bed in place and their written care plan directed staff to keep their bed in the lowest position.

PSW #119 and RN #133 stated that resident #032's bed should always be in the lowest position as they were at risk for falling.

PSW #119 acknowledged that on the identified date, resident #032's bed was not in the lowest position as directed by their plan of care.(696) [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs had changed or care set out in the plan was no longer necessary.

a) Resident #005 had a fall on an identified date that resulted in injury. The resident was assessed post fall and a device was put in place as a fall prevention intervention.

Resident #005's written plan of care did not specify the use of the device and did not include any information regarding the acquired area of altered skin integrity. There was no other documentation to indicate that the resident's plan of care was reviewed and revised to include the new fall prevention interventions or new skin issues.

PSW #108 stated that they utilized the resident's care plan or kardex to provide them with information on any skin issues that residents may have. They also shared that they depended on the resident's written plan of care to implement fall prevention interventions.

PSWs #107, #108, and #113 stated that they were not aware of the identified area of altered skin integrity for resident #005.

The home's policy "Fall Prevention" with a revision date of January 2015, directed registered staff to update the resident's plan of care post fall with any new interventions.

The home's policy "Skin & Wound Care Management" with a revision date of April 2018, directed registered staff to update the resident's plan of care after a new skin issue was identified.

Resident #005's written plan of care was reviewed with RN #109 and they acknowledged that the resident's plan of care was not reviewed and revised to include the device for falls prevention and the area of altered skin integrity when their care needs had changed.

b) Resident #011 had a fall on an identified date, resulting in an injury.

The resident was assessed post fall and it was determined that using identified devices would be an effective fall prevention strategy.

Resident #011's written plan of care was reviewed and it did not specify the use of the identified devices.

Resident #011's written plan of care was reviewed with RPN #123 and they acknowledged that the resident's plan of care was not reviewed and revised to include the use of the identified devices when their care needs had changed.

c) On an identified date, RPN #130 documented in resident #006's progress notes that the resident had a change in condition. Seven days later, RD #118 observed the resident and made changes to their diet orders.

The plan of care had not been revised when the resident was reassessed by RD

#118 and their care needs changed. (694)

d) Resident # 030 was observed throughout the inspection as non-ambulatory and in a wheelchair.

PSW # 131 stated that resident #030 used a specific lift and a wheelchair since their change in condition.

When asked how staff knew what interventions to use with resident #030, BSO RPN #130 showed the Inspector the morning care routine posted on the resident's closet.

On an identified date, the written plan of care and the instructions to staff posted on the resident's closet drawer were reviewed. The plan of care continued to state that the resident ambulated using an assistive device with one assist and the Morning Care Routine document stated that the resident required assistance to stand,walk to the washroom, and be provided care in the washroom.

RPN # 130 confirmed that resident #030's plan of care had not been updated to address the resident's changed abilities and needs. (539) [s. 6. (10) (b)]

3. The licensee has failed to ensure that when the resident was being reassessed and the plan of care was being revised because care set out in the plan had not been effective, different approaches had been considered in the revision of the plan of care.

a) The clinical records of resident #005 were reviewed and revealed that they had three falls during a twenty-three day period. The resident was re-assessed after each fall but there was no documentation to indicate that different fall prevention interventions were considered in the revision of the plan of care.

The resident's written plan of care did not identify any new approaches or fall prevention interventions that were considered and tried between the specified time period.

A Critical Incident (CI) report was submitted by the home stating that resident #005 had a fall three days later, resulting in an injury.

RN #109 stated that it was an expectation that the resident was assessed after

each fall and different approaches were considered in the revision of the plan of care. They acknowledged that different approaches were not considered for resident #005, when the fall prevention interventions in place were ineffective.

b) The clinical records of resident #007 revealed that they had three falls during a three day period. They were assessed after each fall but there was no documentation to indicate that different fall prevention interventions were considered in the revision of the plan of care.

A CI report was submitted to the Ministry of Health and Long Term Care (MOHLTC) stating that resident #007 had a fall on day three of the identified period, resulting in an injury.

The home's policy "Falls Prevention" with a revision date of January 2015, directed registered staff to complete an assessment post fall and to consider interventions with the multidisciplinary team.

DOC #101 acknowledged that different approaches were not considered for resident #007 when the fall prevention interventions in place were ineffective. [s. 6. (11) (b)]

***Additional Required Actions:***

**CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

***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 resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs change or care set out in the plan is no longer necessary, to be implemented voluntarily.***

**WN #3: 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 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, except as provided for in the regulations.

Review of the registered staff schedules from October 18, 2018 to March 28, 2019 was completed.

The review showed that agency Registered Nurses (RN) worked a total of 16 shifts during this period.

The schedules also showed that there was no RN on duty and present in the home form 1400 to 2200 hours on an identified date. The shift was worked by two Registered Practical Nurses (RPN).

Staff schedules were reviewed with the Office Manager #104. The Office Manager reviewed the agency schedules and agreed that the above dates were worked by agency RNs except for the identified shift that was worked by two RPNs.

During an interview with Director of Care #101, they shared that they used agency RNs when they were not able to staff with their own Registered Nurse. They shared that if an agency RN was working in the home, the home had their own Registered Practical Nurse working in the building. DOC #101 shared that it was their understanding that if they had their own RPN working in the home with the agency RN that it was okay.

The licensee 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, except as provided for in the regulations. [s. 8. (3)]

***Additional Required Actions:***

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

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**WN #4: 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 :**

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

a) Resident #008's wheelchair was observed during the course of inspection for a ten day period, and the same stain was noted on their cushion.

The document tilted, "Monthly Equipment Cleaning Schedule for TW1 and TW2" indicated that resident #008's wheelchair was scheduled to be cleaned weekly on an identified day and it was documented that it was last cleaned on a specific date.

PSWs #113, #119, and #127 stated that the residents' wheelchairs were scheduled to be cleaned on weekly basis during the night shift but it was all staff's responsibility to keep the wheelchair clean and sanitary.

Director of Recreation #138 stated that they were responsible for creating the cleaning schedule and would look at it on a daily basis to ensure that staff were signing off on it. They added that there was no formal process in place to ensure that the wheelchairs were being cleaned by the staff as directed. They

acknowledged that resident #008's wheelchair was not cleaned and that the staff assigned had just signed off on the schedule without completing the task.

The licensee has failed to ensure that resident #008 had their equipment, specifically wheelchairs, kept clean and sanitary.

b) Flooring in the home, specifically in six identified resident rooms, snoozelin room, tub room, shower room, library, and hallways was observed to be dirty and stained during this inspection. The floor between the two back exit doors on Trillium and Poppy Lane units had cobwebs and bugs on them.

Housekeeping staff #135 stated that they mop the floors daily however, buffing of the floors had not been completed since December 2018.

The home's policy "Spray Buffing Floors-Housekeeping" with the revision date of September 2015, directed housekeeping staff to buff the floors monthly for high traffic areas and quarterly for moderate traffic areas.

The Director of Dietary Services (DDS) #143, the designated lead for housekeeping services, acknowledged that flooring in the home was dirty and stained. They added that the home's Executive Director was aware of this and had brought it to their attention.

c) On three identified days, it was observed that the raised toilet seats, in five resident rooms, were soiled and stained. Also, a commode sitting outside of an identified resident room was observed to be dirty and had dust on it.

Housekeeping staff #135 and #137 stated that they were responsible for cleaning toilets, commodes, and raised toilet seats on a daily basis.

DDS #143 acknowledged that the toilet seats and commodes in the specified rooms should have been cleaned. They added that PSWs were also responsible for cleaning up the toilets after they had toileted a resident.

d) During this inspection, it was observed that the insides of the window panes in six resident rooms and library were dirty. There were cobwebs, leaves, dead insects, soil, and dust present.

Housekeeping staff #137 stated that insides of the windows were usually cleaned

for one room on a weekly basis. They agreed that the window panes in and identified room were dirty.

The home's policy "Window Washing-Inside-Housekeeping" last revised on December 2017, directed housekeeping staff to clean inside of the windows on an annual basis or more frequently as required to prevent soil build up and to allow for a bright, clean appearance.

DDS #143 stated that the outside of the windows and window screens were cleaned once a year however, there was nothing in place to keep the insides of the windows clean. They added that they were trying to find something that they could use to clean the insides of the window on a daily basis. They acknowledged that the insides of the windows were dirty and were not being cleaned by staff.

e) During this inspection, it was observed that the ceiling fan in the library; wall mounted fans in the tub room and hallways were dusty and dirty. Also the ceiling vents in the shower room, tub room, and hallways were dusty.

Housekeeping staff #135 and DDS #143 stated that the fans and vents were to be cleaned on a daily basis. However, housekeeping staff #137 said that they were cleaned monthly.

The home's policy "Rotational Cleaning-Housekeeping" last revised January 2015, directed housekeeping staff to dust all vents on a monthly basis.

DDS #143 acknowledged that the ceiling fans, wall mounted fans and vents were dusty. They stated that housekeeping staff were only wiping the ceiling fans and wall mounted fans down from the outside, however now maintenance would inspect and clean them on weekly basis. They stated that this was not being done earlier and was something new that was being implemented.

DDS #143 confirmed that there was no plan in place to clean and inspect the ceiling vents. They were unaware of when the vents were last cleaned.

f) On three identified days, cobwebs were noted under the chair in an identified resident room, under the ceiling fan in the library, on the window in an identified resident room, and on the baseboard in another identified resident room by the doorway.

The home's policy "Rotational Cleaning-Housekeeping" with a revision date of January 2015, directed housekeeping staff to dust window ledges, baseboards, walls, and furniture and to check for any cobwebs on monthly basis.

DDS #143 acknowledged that cobwebs should not have been present in the specified rooms. They stated staff should have been checking for cobwebs and dusting as it was part of their schedule.

During this inspection, a tour was conducted along with DDS #143 to show them the identified housekeeping deficiencies and they acknowledged that the deficiencies existed.

g) On two identified days, it was observed that ceiling in five resident rooms and library were dirty and had stains on them. Also, stains were noted on the wall in a resident room.

The home's policy "Housekeeping cleaning Frequency Schedule" with a revision date of January 2015, directed housekeeping staff to clean walls and ceilings in residents' rooms and common areas on monthly basis.

During an interview with DDS #143, they were unsure of when the walls and ceilings in the home were last cleaned. They were unable to provide the cleaning schedule for it. They said it was their expectation that staff were checking for any spots or stains on the walls and ceilings on daily basis and cleaning them immediately. The acknowledged that ceilings and walls should have been cleaned.

h) During this inspection, it was noted that chairs at both nursing stations were dirty. There was dried up mud present on the legs and bases of the chairs.

The home's policy "Housekeeping cleaning Frequency Schedule" with a revision date of January 2015, directed housekeeping staff to clean office chairs at the nursing station on a weekly basis.

DDS #143 stated that housekeeping staff were responsible for cleaning the floors at the nursing station, however, they were unaware of any schedule or process that was in place to clean the furnishings at the nursing station. They acknowledged that chairs were dirty and process should have been implemented

to clean them.

The licensee has failed to ensure that the home, furnishings, and equipment were kept clean and sanitary. [s. 15. (2) (a)]

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

a) On an identified day, it was noted that counter tops in most of the residents' washrooms were painted white. The paint was peeling off from the counter tops in six resident washrooms and green material was exposed underneath.

A review of home's maintenance care indicated that requests had been sent to maintenance staff, informing them of the counter tops requiring paint in ten identified resident washrooms.

The home's policy, "Work Order Requisitions" with a revision date of January 2015, directed all staff to send in an electronic requisition for any maintenance related concerns and the Environmental Services manager or designate to review all the work requisitions on daily basis.

DDS #143 stated that it was an ongoing issue and the counter tops should never have been painted white in the first place. They stated that they had brought their concerns forward several times to the previous maintenance lead but nothing was done to fix it. They acknowledged that they were aware that the counter tops in the resident's washrooms were not in good state of repair.

b) During the course of this inspection, the following areas of concerns were identified:

-There were scratch marks on the walls, doors, railings, and baseboards in the hallways and in five identified resident rooms. There were also holes in the wall of an identified resident room.

-The paint was peeling off the walls in the hallways, doors, resident rooms, from the ceiling in an identified resident room, snoozelin room, and from the closet doors.

-A part of the door was missing in a resident room. The metal corner guard and

construction material of the wall was exposed in five identified resident rooms and in a resident washroom.

-The baseboards were missing in four resident rooms and was separated in another resident room.

-The closet door in a resident's room was missing and the closet door in another resident room was off the hinges.

-One of the supports on the window in a resident room was coming off. The window in another resident room would not shut completely and the window frame in another resident room was broken.

-The privacy curtains were coming off the tracks in an identified resident room, tub room, and shower room.

The home's policy "Preventative Maintenance Task Schedule" last revised on November 2017, directed maintenance staff to complete resident room inspection on a quarterly basis. The inspection included painting, plumbing, safety, maintenance, hardware, and wall finishes. Each room was to be inspected at least twice a year.

The home's maintenance binder was reviewed and there was no documentation to indicate that all rooms were inspected in 2018.

The Environmental Services Manager (ESM) #145 from Owen Hill Care Community during their tour of the home along with DDS #143, identified maintenance issues like wall damage, missing baseboards, paint peeling off, and closet doors missing, misaligned, or coming off. They said that if maintenance and housekeeping were doing their daily audits then it should never come to this.

DDS #143 stated that they were unsure if all residents' rooms and hallways were being inspected as required. They said there was no maintenance aid present in the home during an identified week during the inspection. They added that they had no previous experience with maintenance services and had not been doing any audits for maintenance. They acknowledged that home's walls, doors, windows, ceilings, closet doors, and baseboards were in disrepair and should have been dealt with on regular basis.

c) During this inspection, it was noted that the tiles in the washroom of an identified resident room were lifting off. There were missing tiles in an identified resident room and Trillium nursing station and cracked tiles in three identified resident rooms.

RN #109 stated that tiles in the nursing station had been missing for a few years and maintenance was well aware of this.

During an interview with DDS #143, they stated that they were aware that the flooring in the specified areas was in poor condition. They acknowledged that maintenance requests were sent for these issues but nothing was put in place to rectify these concerns.

The licensee has failed to ensure that the home and its furnishings were maintained in a safe condition and in a good state of repair. [s. 15. (2) (c)]

***Additional Required Actions:***

**CO # - 005, 006 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# 006**

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**WN #5: 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 :**

1. The licensee has failed to ensure that resident # 037 was protected from abuse by anyone.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “sexual abuse” means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A progress note, stated that resident #037 reported that on two occasions other identified residents had made remarks of a sexual nature towards them. This conversation was witnessed. Eighteen days later, resident #037 reported another incident of a sexual nature by the same identified residents.

Record review of resident #023 revealed that there was a documented incident of a sexual nature towards resident #038.

An assessment for resident #023 was initiated on an identified date, but had not been completed or finalized.

A Referral Form was completed and faxed for resident #023 after the incident, however, no further documentation could be located.

In an interview, resident #037 stated that they recalled the two events and were very upset.

The licensee failed to ensure that resident # 037 was protected from abuse by anyone. [s. 19. (1)] [s. 19. (1)]

2. The licensee failed to ensure that residents were not neglected by the licensee or staff.
For the purposes of the Act and this Regulation, "neglect" means the failure to

provide a resident with the treatment, care, services, 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. O. Reg. 79/10, s. 5.

a) Resident #008's clinical records identified that they had a fall on an identified date.

The next morning, resident #008 was observed sleeping in their bed and there were areas of altered skin integrity noted. The call bell at their bed side was not working..

Two PSWs shared that the call bell in resident #008's room had been broken and they had reported it. They stated that resident #008 relied on their call bell.

Resident #008's care plan revealed that they were able to ask for assistance from staff.

There was no documentation to indicate that any interventions were put in place to closely monitor the resident while the call bell was not functioning prior to the fall.

ADOC #102 stated that they were aware that resident #008's call bell was broken however no actions were taken by them to ensure that resident #008 had something in place so that they could call for assistance when needed.

During an interview with DOC #101 they acknowledged that this was considered neglect as no action was taken by the home to fix resident #008's call bell and they subsequently fell.

The licensee has failed to ensure that resident #008 was not neglected by the licensee or staff.

b) A complaint was reported to the MOHLTC regarding an allegation of neglect by staff towards resident #013.

Resident #013's progress notes showed that Registered Nurse (RN) #133 documented on an identified date, that the resident had an area of altered skin integrity. Eight entries over ten days in the resident's progress notes stated the

resident had altered skin integrity. Assessments related to skin and wound, pain, vital sign monitoring and communication to the substitute decision maker (SDM) were not completed during the ten day period. There were no interventions put in place to address resident #013's change in condition.

RN #133 and #141 acknowledged that resident #013 did not receive assessments and treatments for the area of altered skin integrity for a ten day period and required hospitalization.

Registered staff #106, #134, ADOC #102 and DOC #101 stated it was the home's expectation that an initial skin assessment would be completed for areas of altered skin integrity. All staff interviewed confirmed that not providing care, assessments or treatments would be considered neglect.

The licensee failed to protect #013 from neglect that jeopardized their health and well-being.

c) A complaint was received by the MOH with an allegation of neglect by staff towards resident #006.

Review of the clinical record for resident #006 showed that for an identified twenty-seven day period resident #006 had a change in condition.

There were no nursing assessments, no documented communication with the physician and no interventions put in place regarding resident #006's change in condition.

The licensee failed to protect #006 from neglect that jeopardized their health and well-being. [s. 19. (1)]

***Additional Required Actions:***

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

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

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**WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training**

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

**s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:**
**1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).**
**2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).**
**3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).**
**4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).**
**5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).**
**6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).**
**7. Fire prevention and safety. 2007, c. 8, s. 76. (2).**
**8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).**
**9. Infection prevention and control. 2007, c. 8, s. 76. (2).**
**10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).**
**11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that RPN #132, RN #146, RN #147, RN #154, RN #155, RN #159 and DOC #101 received training before performing their responsibilities as required by this section.

Office Manager #104 shared that the home continues to use agency RNs, RPNs and PSWs when needed. They stated that the home used three agencies.

During an interview with Office Manager #104, a review of the schedules showed that agency RNs #154, #155 and #159 had worked at the home after the

compliance order due date of September 28, 2018.

Review of the home's agency orientation records was done and showed that RN #154, RN #155 and RN #159 signed that they had orientation on identified dates. It was noted on review of the orientation records that RN #154, #155, #159 had not completed orientation to the homes' falls prevention and management, skin and wound care, continence care and bowel management, and pain management programs.

Office Manager #104 acknowledged that the agency orientation binder did not include policies on falls prevention and management program, skin and wound care program, continence care and bowel management program and pain management program.

A review of the schedule showed that agency RN #146 had worked in the home on three identified dates between October 27, 2018 and January 1, 2019. Office Manager #104 was not able to provide agency RN #146's orientation checklist or a sign off of policies done by this individual. On an identified date, Office Manager #104 provided an orientation checklist that agency RN #146 had faxed the home that day, however, there was no date to indicate when the orientation would have been completed.

RPN #132 was hired on an identified date. During an interview, RPN #132 agreed that they did not complete any education prior to performing their duties regarding the skin and wound care, falls prevention and management, continence care and bowel management and pain management program.

Review of the orientation records showed that RPN #132 had not completed orientation to the skin and wound care, falls prevention and management, continence and bowel management and pain management programs.

RN #147 was hired on an identified date. Review of their orientation records showed that they had not completed orientation on the long-term care home's mission statement, skin and wound care, falls prevention and management, and pain management programs.

DOC #101 started in their role on an identified date. A review of DOC #101's employee file/ orientation package showed that the home's policy to promote zero tolerance of abuse and neglect was signed forty days after they started in their

role; and infection prevention and control was signed sixty-two days after they started in their role. A review of DOC #101's Relias transcripts from date of hire to present showed that Privacy and Security and Hazardous Chemicals was completed a total of 0.5 hours.

During an interview with DOC #101 they were not able to provide any information showing that they had orientation/training to the following prior to performing their responsibilities: the Residents' Bill of Rights; the long-term care home's mission statement; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; fire prevention and safety; emergency and evacuation procedures; infection prevention and control; and all acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities; and any other areas provided for in the regulations.

During an interview with Assistant Director of Care #102 they shared that they were the designated lead for education in the home. Assistant Director of Care #102 was not able to provide any information on orientation for agency RNs , RPNs and PSWs for the skin and wound care, falls prevention and management, continence care and bowel management and pain management programs.

ADOC #102 shared that registered staff hired by the home had approximately 30 programs in Relias to complete when they were a new hire.

ADOC #102 was not able to provide any education records regarding the skin and wound care, falls prevention and management, continence care and bowel management and pain management program for RPN #132. RPN #132 had completed 15 Relias modules from date of hire.

ADOC #102 was not able to provide any education records regarding the long-term care home's mission statement, skin and wound care, falls prevention and management, and pain management programs for RN #147. RN #147 had completed 12 Relias modules from date of hire.

The licensee failed to ensure that RPN #132, RN #146, RN #147, RN #154, RN #155, RN #159 and DOC #101 received training before performing their responsibilities as required by this section. [s. 76. (2)]

***Additional Required Actions:***

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

**(A3)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 008**

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**WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system**

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

**s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,**
**(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).**
**(b) is on at all times; O. Reg. 79/10, s. 17 (1).**
**(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).**
**(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).**
**(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).**
**(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).**
**(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home was equipped with a resident-staff communication response system that could be easily seen, accessed and used by residents, staff and visitors at all times.

a) On an identified date, the call bell cord was missing in the washroom for resident #039.

PSW #127 stated that if a washroom call bell was not functioning it would cause the call bell at the bedside in the same room to not work.

Resident #039 was without a call bell for 18 hours. Staff stated they were to complete checks every 15 minutes if a resident's call bell was not working, but checks were not documented.

b) On an identified date, it was observed that the call bell in the washroom of and identified room was not available.

PSW #113, #127, and #129 stated that resident #026 did not have access to a call bell in their washroom for 2 days. They said that resident #026 relied on their call bell to get staff assistance.

A review of the maintenance care log revealed that a maintenance care request was sent.

c) On an identified date, it was observed that the call bell between the beds of resident #008 and #040 was not available.

Two PSWs shared that the call bell in resident #008's room had not been available for one day. They stated that resident #008 relied on their call bell.

During an interview with DOC #101 and ADOC #102, they both stated that call bells should always be available for residents at their bedside and in their washrooms.

DDS #143 acknowledged that the call bells were not available for the identified residents. They said that a maintenance requests were sent but they had not been checking the maintenance log daily as required.

The licensee failed to ensure that residents and staff had access at all times to the resident-staff communication response system.

***Additional Required Actions:***

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

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**WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 24. 24-hour admission care plan**

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

**s. 24. (1) Every licensee of a long-term care home shall ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home. O. Reg. 79/10, s. 24 (1).**

**s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:**
**1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks. O. Reg. 79/10, s. 24 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the home had a 24-hour admission care plan developed for resident #039 and communicated to the direct care staff within 24 hours of resident #039's admission to the home.

Long Term Care Home (LTCH) Inspector #694 observed PSW #107 speaking to resident #039 . The PSW was not aware of the resident's name, diet type, texture, fluid consistency or if they had any dietary restrictions. The PSW was offering the resident something from the nourishment cart and the resident was not on the resident list provided to staff.

PSW #127 stated they were not aware a resident had been admitted until they observed a resident in the room. Nothing was said during change of shift report,

but when the PSW checked they saw the resident's name on their point of care assignment. The staff member stated they were not aware of the resident's care needs after reviewing their kardex.

The clinical record for resident #039 was reviewed. Staff were not aware of resident #039's care needs.

The licensee failed to ensure that the home had a 24-hour admission care plan developed for resident #039 and communicated to the direct care staff within 24 hours of resident #039's admission to the home. [s. 24. (1)]

2. The licensee has failed to ensure that the 24-hour admission care plan included, at a minimum, any risks the resident posed to himself or herself, including any risk of falling, and interventions to mitigate those risks.

Resident #011 was admitted to the home on an identified date with a history of falls.

A fall risk assessment was completed upon admission and it identified that resident #011 was at risk for falling.

The clinical records of resident #011 were reviewed and there was no documentation to indicate that any interventions were put in place upon admission to mitigate the resident's risk of falling.

The resident's 24 hour admission care plan did not include their risk of falling and any interventions to mitigate those risks.

After admission to the home, resident #011 had a fall which resulted in injury.

The home's policy "Falls Prevention" policy directed registered staff to complete the Falls Risk Assessment within 24 hours of admission and to update the care plan with associated risk level and interventions.

RPN #123 acknowledged that the resident's 24-hour admission care plan did not include their risk of falling and any interventions to mitigate those risks. [s. 24. (2) 1.]

***Additional Required Actions:***

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

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a 24-hour admission care plan is developed for each resident and communicated to direct care staff within 24 hours of the resident's admission to the home, to be implemented voluntarily.***

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**WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 25. Initial plan of care**

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

**s. 25. (1) Every licensee of a long-term care home shall ensure that,**
**(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and O. Reg. 79/10, s. 25 (1).**
**(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that the assessments necessary to develop an initial plan of care were completed within 14 days of the resident's admission; and the initial plan of care was developed within 21 days of the admission.

a) Resident #031 was admitted to the home on an identified date. Review of their Minimum Data Set (MDS) admission assessment, 23 days post admission, showed that 17/20 sections of the assessment were not completed.

Review of the initial plan of care contained no information regarding customary

routines; cognition ability; communication abilities, including hearing and language; vision; mood and behaviour patterns; psychological well-being; physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming; continence, including bladder and bowel elimination; dental and oral status, including oral hygiene; skin condition; activity patterns and pursuits; drugs and treatments; sleep patterns and preferences; cultural, spiritual and religious preferences and age-related needs and preferences.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long Term Care on an identified date, for alleged abuse of resident #031 by staff. The initial plan of care did not include the type of assistance resident #031 required for toileting and care requirements regarding continence care.

b) Resident #033 was admitted to the home on an identified date. Review of their MDS admission assessment, 28 days post admission, showed that 14/20 sections of the assessment were not completed.

Review of the initial plan of care contained no information regarding cognition ability; communication abilities, including hearing and language; mood and behaviour patterns; psychological well-being; physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming; continence, including bladder and bowel elimination; dental and oral status, including oral hygiene; skin condition; drugs and treatments; cultural, spiritual and religious preferences and age-related needs and preferences.

c) Resident #020 was admitted to the home on an identified date. Review of their MDS admission assessment, 24 days post admission, showed that 14/20 sections of the assessment were not completed.

Review of the initial plan of care contained no information regarding cognition ability; continence, including bladder and bowel elimination; skin condition; drugs and treatments; cultural, spiritual and religious preferences and age-related needs and preferences.

ADOC/RAI Coordinator #103 agreed that resident #031, #033 and #020 were not assessed within 14 days of the resident's admission and the initial plan of care was not developed within 21 days of admission.

For residents #020, #031 and #033, the licensee failed to ensure that the assessments necessary to develop an initial plan of care were completed within 14 days of the resident's admission; and the initial plan of care was developed within 21 days of the admission. [s. 25. (1)]

***Additional Required Actions:***

**CO # - 011 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #10: 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. (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 failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs.

Review of the home's staffing plan for PSWs was completed.

During an interview with Staffing Coordinator #139 they shared that the home had four part time PSWs plus 2 part time PSWs that worked short shifts. The home had one casual PSW and were having to use agency PSWs to assist with covering the PSW shifts.

A review of PSW hours for two 14 day periods was done.

For one period, the home had 272.04 vacant PSW hours.
For another period, the home had 316.80 vacant PSW hours.

Resident #015 and #027 shared that they did not get their bath on an identified date as there was not enough staff. Resident #015 shared that they felt this happened every month.

Six personal care staff expressed that they worked short on a frequent basis. They shared that the bathing/feeding shifts got pulled to work on the floor therefore residents were not getting their bath. When this happened they shared that the direction they were given was to give the residents a bed bath.

On an identified date, the two bathing/feeding shifts from 0600-1400 hours were pulled to work on the floor. This resulted in 13/14 residents not receiving their scheduled baths, but they were given a bed bath instead.

PSW #129 shared that the home was always short staffed and usually ended up working with six PSWs or less in the home instead of the planned eight PSWs. They shared that they did not get residents toileted as much as they needed nor were baths getting done.

On an identified date, review of the schedule showed that they were short a 0600 to 1400 bathing/feeding shift. PSW #128 shared that as a result of this shortage the residents on the identified list would not receive their bath but were to be offered a bed bath. PSW #128 shared that 8/8 residents were not given their

bath.

PSWs #112 and #140 shared that they worked short on two identified dates. They stated that on both dates, they were short two PSWs from 1400-2200 hours, a PSW from 1700-2100 hours and two bathing/feeding shifts that work 1100-1900 and 1130 to 1930 hours. The 1700-1900 shift was never covered on identified weekends. PSW #112 expressed that they were not able to provide all the care the residents required. During these two identified dates 14/23 residents did not receive their bath/shower.

On an identified date, Inspector 694 observed resident #016 asking RPN #148 to go to bed. RPN #148 informed resident #016 that they would have to wait 30 minutes as staff were busy in the dining room. Review of the staffing for this date was done and PSW #107 shared that they worked short two PSWs from 0600-1400 hours. Resident #016 shared that they wanted to go to bed because they were uncomfortable. The schedule and PSWs #112 and #140 confirmed that they were working with one less PSW from 1400-2200.

Review of the home's staffing plan evaluation provided by DOC #101 on March 26, 2019 was completed. The home's staffing plan was last evaluated on January 4, 2018 and included goals and objectives for 2018.

When DOC #101 was asked if the staffing mix was consistent with the residents' assessed care and safety needs they shared that they had worked as a PSW and stated that PSWs just have to expend more energy to get the work done.

The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs. The licensee failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. [s. 31. (3)]

***Additional Required Actions:***

**CO # - 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

**(A3)**
**The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 012**

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**WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing**
**Specifically failed to comply with the following:**

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

**Findings/Faits saillants :**

1. The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

During interviews three PSWs shared that the bathing/feeding PSW would get reassigned to work a floor assignment if they were short three PSWs on the floor. They said that the direction they had been given when that happened was that the residents that were assigned to the bathing/feeding PSW were to be given bed baths by their assigned PSW.

PSW #127 shared that resident #008 had expressed concern to them that they had gone a week without getting a bath. PSW #127 shared that on an identified date, resident #008 was to get a bath however the bathing/feeding shift was not filled and resident #008 was given a bed bath.

Further review of POC documentation and schedules also indicated that resident

#008 did not receive their bath preference on another identified date.

Review of day baths for two identified dates and afternoon/evening baths for two identified dates showed that 35/45 residents (77 per cent) did not get bathed by their method of choice.

During an interview with Director of Care #101 they shared that if the bathing/feeding shift was reassigned to the floor then those assigned residents would get bed baths. They stated that their was no way of knowing when residents were given a bed bath instead of their bath preference. [s. 33. (1)]

2. During an interview resident #015 they shared that on an identified date, they did not get a tub bath but received a bed bath because there was no staff available to give tub baths. They expressed that this happened approximately once a month.

There was no documentation to support that resident #015 was bathed by the method of their choice. [s. 33. (1)]

3. Resident #027 shared that on an identified date, they did not get their bath and were given a bed bath. Resident #027 also expressed that if the home had a shower area where they could sit in a shower chair their preference would be a shower.

Review of POC documentation for resident #027 showed that staff were not able to document the type of bath that was provided to resident #027 but only able to comment on the amount of self performance and support provided. Review of POC documentation for the identified date and interviews with PSW #128 supported that they gave resident #027 a bed bath and not a tub bath.

PSW #114 shared that the only shower area in the home was located in Tub Room A and only residents that walked could go in the shower.

DOC #101 shared that they were not aware of how residents who could not ambulate were being showered in the home.

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a

medical condition. [s. 33. (1)]

***Additional Required Actions:***

**CO # - 013 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# 013**

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**WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care**

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

**s. 50. (2) Every licensee of a long-term care home shall ensure that,**
**(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,**
**(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,**
**(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,**
**(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and**
**(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).**

**Findings/Faits saillants :**

1. The licensee failed to ensure a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin

assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The clinical record for resident #013 was reviewed and Registered Practical Nurse (RPN) #124 identified that resident #013 had an area of altered skin integrity. A progress note was made on an identified date regarding the altered skin integrity.

RPN #124 and ADOC #102 acknowledged that resident #013 did not have a Skin and Wound Care Assessment completed when the area of altered skin integrity was identified.

The licensee failed to ensure that resident #013 had a skin assessment completed by a member of the registered staff when they had altered skin integrity. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Resident #011 was admitted to the home on an identified date with an area of altered skin integrity.

The clinical records of resident #011 were reviewed and there was no weekly skin assessment completed for their altered skin integrity.

RPN #123 stated that they were aware that resident #011 was admitted with an area of altered skin integrity. RPN #123 acknowledged that the area of altered skin integrity had not been reassessed weekly by registered nursing staff since admission four weeks ago.

b) Resident #005 sustained an area of altered skin integrity after an incident.

The clinical records for resident #005 were reviewed and there was only one skin assessment that was completed.

There was no other documentation to indicate that staff had completed weekly

skin assessments for the area of altered skin integrity for five weeks.

RN #109 stated that after a new skin issue was identified, registered staff were expected to do a weekly skin assessment until the skin issue had been resolved. They reviewed the weekly skin assessments for resident #005 and acknowledged that the registered staff did not complete any weekly skin assessments for resident #005.

RN #109 stated that the area of altered skin integrity was healed however there was no documentation to indicate when it healed.

c) RPN #124, RN #133, RPN #134, ADOC #102 and DOC #101 acknowledged that when residents experience altered skin integrity, registered staff were expected to complete an initial wound and treatment assessment in Point Click Care (PCC), then conduct weekly skin reassessments and document in the progress notes.

Resident #013 had an area of altered skin integrity first documented in the progress notes on an identified date. There were no weekly assessments completed during a 10 day period.

The licensee failed to ensure resident #005, #011 and #013 who were exhibiting altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)]

***Additional Required Actions:***

**CO # - 014 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours**

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

**s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,**
**(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).**
**(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).**
**(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

a) At the beginning of the home's inspection, three residents verbalized that they were very unhappy, and discussed the behaviours of two residents.

PSW #136 stated that resident #014 and resident #017 had an identified behaviour, however, they were not harming anyone by doing this.

Progress notes stated that:

On eight occasions during a nine week period, resident #014 and #017 had an identified responsive behaviour.

On five other occasions during a six week period, resident #017, had other identified responsive behaviours.

Circle of Care meeting minutes identified strategies for some of the responsive behaviours.

On numerous occasions during the inspection the identified strategies were not in place and resident #014 and #017 were observed having responsive behaviours.

The Internal Responsive Behaviour Protocol for Creedan Valley Care Community, instructed staff to update the care plan to include descriptions of cues and

triggers, what the escalation would look like, interventions, patterns, environmental risk factors or conditions.

Resident #014 and #017's care plan did not identify the above behaviours or strategies to address the behaviours.

PSW #136 and RPN #130 stated that strategies were not always implemented by staff. RPN #130 stated the home was behind in updating the care plans with behavioural strategies.

b) Resident #014 and #017 were observed on multiple occasions during the inspection.

Resident # 014’s care plan had identified an intervention, as recommended by the BSO team.

During the inspection the identified intervention was not observed to be implemented.

RPN #130 stated staff were not consistent in implementing responsive behaviour strategies.

c) During this inspection, resident #010 described how two residents had responsive behaviours.

Progress notes showed that the resident made the home aware of their frustration with identified residents.

The home submitted a Critical Incident, regarding an altercation between two identified residents.

Resident #010's care plan did not provide strategies to staff.

The “Internal Responsive Behaviour Protocol for Creedan Valley Care Community” stated that care plans should be updated with changes, and should include descriptions of cues and triggers, what the escalation would look like, interventions, patterns, and environmental risk factors or conditions.

Circle of Care minutes stated that the home would ensure that two strategies

were implemented in response to the responsive behaviours.

On multiple observations throughout the inspection these strategies were not implemented.

Resident #010 stated that they were frustrated.

PSW #136 and RPN #130 stated that interventions were not always in place to address resident #010's responsive behaviours.

The licensee has failed to ensure that strategies had been developed and implemented for resident’s #010, #014 and #017 responsive behaviours. [s. 53. (4) (b)]

2. The licensee failed to ensure the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

1. a) Progress notes from an identified month, for resident #030 documented how the resident had certain identified behaviours.

On an identified date, resident #030 had a change in treatment.

The doctor ordered the staff to monitor. Record review did not provide any documentation of the monitoring.

Resident #030 sustained a fall 20 days after the change in treatment.

There was no documentation of resident #030's responses to the interventions as ordered by the physician.

b) A Behaviour progress note documented that resident #030 was having increased physical behaviours and a referral was made to the BSO.

Upon review of resident #030’s record, an electronic Responsive Behavioural Referral to the internal BSO Lead, and a completed DOS, could not be located for this time period.

RPN #130 stated that a DOS was only completed when ordered by the doctor and

the BSO referral only continued when decided upon by the management team.

ADOC #103 was unable to locate an electronic Responsive Behavioural Referral and completed DOS notes for resident #030.

c) The home submitted a Critical Incident report was submitted when resident #030 sustained a injury.

During multiple observations, resident #030 was observed with responsive behaviours.

Six progress notes during a two week period, documented continued responsive behaviours toward staff.

The care plan under behaviours identified an approach to dealing with the resident's responsive expressions.

PSW # 136 stated the behaviour had gotten progressively worse since resident #030 had sustained the injury.

RPN #130 stated resident #030 was not being monitored for responsive behaviours.

ADOC #103 was unable to locate a BSO electronic referral, completed DOS notes, or assessment for resident #030.

2. A progress note completed by ADOC #103, stated resident #037 informed them on an identified date that resident #023 and #038 had responsive behaviours that bothered them very much.

Resident # 023 was known to staff to have responsive behaviours.

An electronic Responsive Behaviours Assessment for resident #023 was initiated ion a specific date, but had not been completed or finalized.

A DOS was started, however, the form was incomplete.

A Referral Form was completed and faxed for resident #023 after the incident, however, no further documentation could be located in the BSO binder, the circle

of care meeting minutes or the resident's chart.

The home's policy entitled, Sexual Expression & Intimacy, policy # VII-G10.02, last revised December 2017, stated that upon becoming aware of a resident's sexual expression, the residents should be assessed using the Lichtenburg Tool for Assessing Sexual Capacity to Consent, and a MMSE be completed.

DOC #101 stated that the home had not considered the behaviour of resident #023 and #038 towards resident #037 inappropriate due to their cognitive status.

3. A Critical Incident report was submitted that regarding alleged abuse between resident #001 and resident #002.

The Interdisciplinary Care Conference summary, for an identified date, for Minimum Data Set (MDS), stated that the resident's aggressive behaviour score (ABS) had worsened.

Review of the progress notes from the time of the Interdisciplinary Care Conference summary until present described how resident #001's behaviours increased.

PSW #107 was unaware that resident #001 had been assessed by the BSO team.

RPN #106 described resident #001's behaviours and stated some interventions they used with the resident.

RPN #130 described how the resident would become upset.

As per the home's "Internal Responsive Behaviour Protocol for Creedan Valley Care Community", for a new behaviour seen or triggered on RAI-MDS, the staff were to open a Responsive Behaviour Assessment in PCC, complete a DOS/ABC charting and analyze the information after one week to identify triggers. The P.I.E.C.E.S. assessment was to be used.

The home's policy entitled, Responsive Behaviours- Management, Policy #: VII-F-10.20, revised November 2018, instructed the Registered Staff to complete an electronic Responsive Behavioural Referral to the internal BSO Lead. The Interprofessional Care Team were to work together to "identify possible triggers

for responsive behaviour based on preliminary evidence based assessments".

Paper copies of the P.I.E.C.E.S. Assessment Worksheets, located in the Behavioural Support Ontario (BSO) binder, were available for the registered staff to complete.

On an identified date, Digital Prescriber's orders stated that the doctor ordered Dementia Observation System (DOS) charting for seven days for aggressive behaviour. The DOS charting was not completed on each day of the monitoring.

RPN #130 stated that they had not been provided the DOS for review, PIECES assessments were not completed by the registered staff and the resident had not been referred to the external Behavioural Support System team.

ADOC #103 confirmed that the home did not complete an electronic Responsive Behavioural Referral or P.I.E.C.E.S. assessment of the resident to reassess the resident, identify interventions and assess the resident's response to interventions.

4. Two progress notes on two identified dates, stated resident #004 demonstrated a new responsive behaviour.

As per the home's "Internal Responsive Behaviour Protocol for Creedan Valley Care Community", for a new behaviour, the staff were to open a Responsive Behaviour Assessment in PCC, complete a DOS/ABC charting and analyze the information after one week to identify triggers. The PIECES assessment was to be used.

The home's policy entitled, Responsive Behaviours- Management, Policy #: VII-F-10.20, revised November, 2018, instructed the Registered Staff to complete an electronic Responsive Behavioural Referral to the internal BSO Lead. The Interprofessional Care Team were to work together to "identify possible triggers for responsive behaviour based on preliminary evidence based assessments".

A treatment was ordered by the physician when needed for responsive behaviours.

DOS charting, a BSO electronic referral, and a PIECES assessment were not completed and therefore there were no triggers identified.

RPN #130 stated that they had not received a BSO referral and had not completed a DOS for resident #004's responsive behaviours.

The licensee failed to ensure that the actions were taken to meet the needs of resident's #030, #023, #001, #004 with responsive behaviours that included: reassessments, interventions, and documentation of the resident's responses to the interventions. [s. 53. (4) (c)]

***Additional Required Actions:***

**CO # - 015 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping**

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

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(a) cleaning of the home, including,**
**(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and**
**(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).**

**s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,**
**(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures were developed and implemented for the cleaning of privacy curtains in the home.

It was observed that the privacy curtain in the tub room had yellow and black stains on it.

Housekeeping staff #137 was unsure of the process that was in place for cleaning and changing privacy curtains in the tub room.

The home's policy "Privacy Curtains & Drapes-Housekeeping" last revised on January 2015, directed housekeeping staff to inspect privacy curtains daily for stains and to send them for cleaning immediately if needed.

DDS #143 was unsure of when the privacy curtains in the tub room were last changed and cleaned. They were unaware if staff were inspecting it on a daily basis as it was not part of their schedule. They acknowledged that a process should have been implemented to keep the privacy curtains in the tub room cleaned.

The licensee has failed to ensure that procedures were developed and implemented for cleaning privacy curtains in the home. [s. 87. (2) (a)]

2. The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours.

a) On identified dates, there were lingering offensive odours detected from the mattresses in three identified rooms.

PSW 119 stated that housekeeping staff were responsible for cleaning mattresses. However, PSWs #113 and #127 stated that they were responsible for cleaning mattresses for the residents on a weekly or as needed basis, however, there was no place for them to document that they had cleaned the mattress. They were unsure of the products and procedures that were in place to address any lingering odours coming from the mattress. They said no clear directions were given to them.

The DDS confirmed that there were lingering offensive odours detected from these mattresses. They stated that PSW staff were responsible for cleaning the

mattresses and should have been using Clorox urine remover to get rid of offensive odours. They acknowledged that PSWs were not aware of this process and did not have access to Clorox urine remover.

b) During this inspection, lingering offensive odours were detected in identified resident living areas.

Housekeeping staff #137 and #144 stated that they used citrus spray and Clorox urine remover to address incidents of lingering offensive odours. They said that both these techniques were ineffective for addressing incidents of lingering offensive odours as some of these odours were part of the home's walls and flooring.

DDS #143 agreed that there were lingering offensive odours present in these specified areas and rooms. They added that this had been an ongoing concern for them as some of the urine had seeped into the flooring. They acknowledged that procedures were not implemented for addressing incidents of lingering offensive odours in these rooms.

The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

***Additional Required Actions:***

**CO # - 016 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services**

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

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).**

**s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,**
**(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection; O. Reg. 79/10, s. 90 (2).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the heating, ventilation and air conditioning systems were cleaned, in good state of repair, and inspected at least every six months by a certified individual, and that documentation was kept of the inspection

On identified dates, it was noted that the ceiling vents in the shower room, tub room, and hallways had copious amount of dust on them. Also, the ceiling vent in the identified hallway, was coming off from the left side as it was not fixed into the ceiling properly. It had rust on it and required painting.

The home's policy "Preventative Maintenance Task Schedule" last revised in November 2017, directed maintenance staff to perform routine monthly checks on HVAC and exhaust fan units and to change HVAC air filters on quarterly basis. HVAC, exhaust fans, and air conditioning units were to be inspected by a contracted service provider on a semi-annual basis and inspection report was to be documented.

A document titled “Risk management schedule form department: Maintenance” was found in the home’s maintenance binder for 2018. It included all the tasks that were scheduled to be completed by maintenance services and their frequency. The sections for HVAC filter changes and equipment inspections were not checked off as being completed for the year of 2018.

During an interview with DDS #143, they were unable to provide documentation of the inspection report for the heating, ventilation, and air conditioning system. They acknowledged that the heating, ventilation and air conditioning systems in the home were not cleaned regularly and inspected every six months by a certified individual.

The licensee has failed to ensure that procedures were implemented to ensure that the heating, ventilation and air conditioning systems were cleaned, in good state of repair, and inspected at least every six months by a certified individual, and that documentation is kept of the inspection [s. 90. (2) (c)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

During this inspection, different room observations were made and the following areas of concerns were identified:

-The lid of the toilet tank in an identified room was not properly fitted as it was approximately 6 inches longer than the tank itself and was differently shaped. The lid extended beyond both ends of the tank.
-There was no lid present on the toilet tank in an identified room.
-The lids of the toilet tanks in two identified rooms did not fit properly.
-The base of the toilets in six identified rooms were black and dirty with no caulking present.

Maintenance care records in the home indicated that requests had been sent by staff regarding the toilet tank lids in two identified rooms.

DDS #143 stated that they were aware that some of the toilets in the home required caulking. They acknowledged that the toilets in the specified rooms were

not maintained and should have been fixed immediately. They agreed that lids of the toilet tanks should have never been missing and should be well fitted.

The licensee has failed to ensure that procedures implemented to ensure that the toilets in the home were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]

3. The licensee failed to ensure that procedures were developed and implemented to ensure that the gas, electric fireplaces and heat generating equipment (other than the home's HVAC system) were inspected by a qualified individual at least annually, and that documentation was kept of the inspection.

On two identified dates, it was observed that the cover of a baseboard heater in the main dining room was coming off, exposing the heating element underneath.

Environmental Service Manger #145 (ESM) from another Sienna care community, observed the broken cover of the baseboard heater and stated that it was a safety risk for the residents as the heating element was exposed.

The DDS #143, the interim lead for home’s maintenance services, said that most of the home had electric baseboard heating except for a unit in the back dining room. They were unable to provide any documentation to show that home’s heat generating equipment was inspected by a qualified individual on an annual basis. They were unsure of when the last inspection took place. They acknowledged that the home’s heat generating equipment was not inspected annually by a qualified individual. [s. 90. (2) (e)]

***Additional Required Actions:***

**CO # - 017 will be served on the licensee. Refer to the “Order(s) of the Inspector”.**

**WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 212. Administrator**

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

**s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:**
**1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week. O. Reg. 79/10, s. 212 (1).**
**2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week. O. Reg. 79/10, s. 212 (1).**
**3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).**

**Findings/Faits saillants :**

1. The licensee failed to ensure that as of January 1, 2011, the home's Administrator worked regularly in that position on site for at least 24 hours per week.

At the start of this inspection, Executive Director #100 shared that this was their second day at the home. They shared that they were also the current Executive Director at Midland Gardens and since their position at that home had not been filled they would be spending two days a week as Executive Director at Creedan Valley Care Community and Director of Care #101 would be covering as the Executive Director one day a week.

During this inspection, Executive Director #100 was observed to be in the home on identified dates.

During an interview with the Director of Care #101 they said that Executive Director #100 was at the home two days a week and in their absence the staff knew that they were to come to them if needed.

The licensee failed to ensure that the home's Administrator worked regularly in that position on site for at least 24 hours per week. [s. 212. (1)]

***Additional Required Actions:***

**CO # - 018 will be served on the licensee. Refer to the "Order(s) of the Inspector".**

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**WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director**

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

**s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:**
**1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).**
**3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).**
**4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).**
**5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).**

**Findings/Faits saillants :**

1. The Licensee has failed to ensure that when they had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director.
1. Improper or incompetent treatment of care of a resident that resulted in harm or a risk of harm.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm.

3. Unlawful conduct that resulted in harm or risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under the Act.

A progress note completed by ADOC #102, stated resident #037 informed them on an identified date of an incident of alleged abuse.

DOC # 101 stated they had not considered the events surrounding the alleged incident abuse because of resident #023 and #038's diagnoses and cognitive abilities, but that upon further review the two events met the definition of abuse.

The home submitted a CIS regarding this incident on an identified date, after the discussion with the Inspector with regards to the definition of abuse and requirements under the legislation.

The licensee failed to ensure that when they had reasonable grounds to suspect that resident #037 had been abused by another resident, they immediately reported the suspicion and the information upon which it was based to the Director. [s. 24. (1)]

2. On an identified date, resident #003 developed an area of altered skin integrity. This was brought to the attention of the registered staff. The PSWs were unable to initially tell the registered staff when or how the area of altered skin integrity developed. The Manager on call was notified by RPN #123 because they were concerned about possible improper care.

On an identified date, the resident was transferred to hospital by the doctor for reassessment as there was further change in the area of altered skin integrity.

Review of Critical Incident reports submitted to the Director showed that there were no reports submitted regarding resident #003 despite the reported suspicion of improper or incompetent treatment of care reported to the Manager on call.

The licensee failed to ensure that when they had reasonable grounds to suspect that resident #003 had received improper or incompetent treatment of care that resulted in harm, they immediately reported the suspicion, and the information upon which it was based to the Director. [s. 24. (1)]

***Additional Required Actions:***

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

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**WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager**

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

**s. 75. (3) The licensee shall ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities. O. Reg. 79/10, s. 75 (3).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that a nutrition manager was on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities.

DDS #143 was the nutrition manager in the home. They stated that they were also responsible for laundry, housekeeping, and maintenance services provided in the home.

The home's occupancy for the week of March 25, 2019, was at 97 percent. The minimum hours for the nutrition manager were calculated at 31.04 hours per week.

DDS #143 stated that they worked 37.5 hours each week out of which they spent nine hours on housekeeping and laundry services. They couldn't't estimate the number of hours they spent on maintenance services but stated that they had dedicated a few hours this week on it.

DDS #143 provided a breakdown of their hours which revealed that they spent 28.5 hours per week on nutrition and dietary services. They acknowledged that they did not meet the minimum number of hours per week as calculated under subsection (4). [s. 75. (3)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a nutrition manager is on site at the home working in the capacity of nutrition manager for the minimum number of hours per week calculated under subsection (4), without including any hours spent fulfilling other responsibilities, to be implemented voluntarily.***

**WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,**
**(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;**
**(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;**
**(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;**
**(d) that the changes and improvements under clause (b) are promptly implemented; and**
**(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.**

**Findings/Faits saillants :**

1. The licensee failed to ensure that at least once every calendar year, an evaluation is made to determine the effectiveness of the licensee's prevention of abuse and neglect policy, that the results of the analysis of each incident are included in the evaluation, that changes and improvements are promptly implemented and that a written record of everything, including the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes or improvements were implemented promptly is prepared.

In an interview with DOC #101 they stated there was no analysis of each incident of abuse or neglect in the home.

A document titled 'Quality Management –LTC Program/Committee Evaluation Tool', date of the report, January 4, 2018, program evaluation for prevention of abuse and neglect program was reviewed. The evaluation did not include an evaluation of the effectiveness of the policy, results of an analysis of incidents and changes or improvements required to prevent further occurrences.

The licensee failed to ensure that an analysis of every incident of abuse and neglect was completed, that at least once a year an evaluation of the effectiveness of the prevention of abuse and neglect policy was completed and included the results of each analysis and the dates that changes or improvements was completed. [s. 99. (e)]

***Additional Required Actions:***

***VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared, to be implemented voluntarily.***

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**WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs**

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

**s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).**

**s. 131. (4) A member of the registered nursing staff may permit a staff member who is not otherwise permitted to administer a drug to a resident to administer a topical, if,**
**(a) the staff member has been trained by a member of the registered nursing staff in the administration of topicals; O. Reg. 79/10, s. 131 (4).**
**(b) the member of the registered nursing staff who is permitting the administration is satisfied that the staff member can safely administer the topical; and O. Reg. 79/10, s. 131 (4).**
**(c) the staff member who administers the topical does so under the supervision of the member of the registered nursing staff. O. Reg. 79/10, s. 131 (4).**

**Findings/Faits saillants :**

1. The licensee failed to ensure a resident was administered drugs as directed by the prescriber.

On an identified date, resident #013 was ordered medication by the physician.

The electronic treatment administration record (eTAR) identified that the treatment was not signed as applied for three identified times.

RN #141 stated that if the medication was not signed in the resident's eTAR, the medication may or may not have been given. Five entries on the eTAR stated 'drug refused', the progress note was signed and did not state the medication/drug was refused.

The licensee failed to ensure that resident #013 was administered medication in accordance with the directions for use specified by the physician. [s. 131. (2)]

2. The licensee failed to ensure that a member of the nursing staff may permit a staff member who is not otherwise permitted to administer a topical if, the staff member has been trained by a member of the registered nursing staff in the administration of topicals.

PSW #107 shared that they had not had any training by the registered nursing staff in the home on the administration of topicals. They stated that they did get asked by registered staff in the home to apply them and had applied topicals when asked.

PSW #113 shared that they had not been trained on the administration of topicals and when registered staff asked them to apply topicals they refused.

RN #141 shared that some PSWs applied topicals as management said it could be delegated. They were not sure if staff were educated or not and said it was a "gray" area.

DOC #101 shared that some PSWs applied topical creams.

ADOC #102 shared that there was no formalized education for the PSWs regarding administration of topicals and they were unable to provide any education or training records regarding the administration of topicals.

The home's policy "PSW Application of Topical Ointments", policy number VIII-F-10.80, current revision July 2015, stated the RN/ RPN will teach and assign individual PSW to apply topical ointments safely.

The licensee failed to ensure that PSW staff were trained in administration of topical ointments. [s. 131. (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 drugs are administered to residents in accordance with the directions for use specified by the prescriber and to ensure that a member of the nursing staff may permit a staff member who is not otherwise permitted to administer a topical if, the staff member has been trained by a member of the registered nursing staff in the administration of topicals, to be implemented voluntarily.***

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**WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements**

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

**s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:**
**1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).**
**2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).**
**3. The program must 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. 30 (1).**
**4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).**

**Findings/Faits saillants :**

1. The licensee has failed to ensure that the written record relating to the falls prevention and management program and the skin and wound care program evaluations included the date of the evaluation, names of the persons who participated, summary of the changes made, and date that those changes were implemented.

The home's 2018 annual evaluations for the falls prevention and management and the skin and wound care programs were reviewed.

The written records did not include the date when the changes were implemented for either programs.

DOC # 101 acknowledged that the written records relating to the falls prevention and management and the skin and wound care program evaluations did not include the dates when the changes were implemented. [s. 30. (1) 4.]

**Issued on this 27th day of January, 2020 (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

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

| | |
|---|---|
| **Name of Inspector (ID #) / Nom de l'inspecteur (No) :** | Amended by SHARON PERRY (155) - (A4) |
| **Inspection No. / No de l'inspection :** | 2019_773155_0007 (A4) |
| **Appeal/Dir# / Appel/Dir#:** | |
| **Log No. / No de registre :** | 024923-18, 027747-18, 027750-18, 027753-18, 027757-18, 027758-18, 027761-18, 027764-18, 027765-18, 027767-18, 029896-18, 033380-18, 033400-18, 002919-19, 003499-19, 003666-19, 003948-19, 005805-19, 006253-19, 007064-19 (A4) |
| **Type of Inspection / Genre d'inspection :** | Follow up |
| **Report Date(s) / Date(s) du Rapport :** | Jan 27, 2020(A4) |
| **Licensee / Titulaire de permis :** | 2063412 Ontario Limited as General Partner of 2063412 Investment LP<br>302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8 |
| **LTC Home / Foyer de SLD :** | Creedan Valley Care Community<br>143 Mary Street, CREEMORE, ON, L0M-1G0 |
| **Name of Administrator / Nom de l'administratrice ou de l'administrateur :** | Debbie Fleming |

To 2063412 Ontario Limited as General Partner of 2063412 Investment LP, 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

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

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

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.
13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.
14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.
15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.
16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.
17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,
i. the Residents' Council,
ii. the Family Council,
iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,
iv. staff members,
v. government officials,
vi. any other person inside or outside the long-term care home.
18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.
19. Every resident has the right to have his or her lifestyle and choices respected.
20. Every resident has the right to participate in the Residents' Council.
21. Every resident has the right to meet privately with his or her spouse or

another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

**Order / Ordre :**

**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

The licensee must be complaint with s.3.(1) 8. of the LTCHA.

The licensee shall prepare, submit and implement a plan to ensure that the resident' right to being afforded privacy when bathing/showering is fully respected and promoted. The plan must include, but is not limited to the following:

a) Review, develop, and implement a bathing schedule that allows for resident #015, #017 and all other residents residing in the home to receive their bath while being afforded privacy in the tub room, which includes no other residents being bathed at the same time in the same tub room.

b) The plan shall include who in the home is responsible for reviewing, developing and implementing the bathing schedule. The plan shall also include what monitoring will be done to ensure that the plan is being followed.

Please submit the written plan for achieving compliance for inspection 2019_773155_0007 to Sharon Perry, LTC Homes Inspector, MOHLTC, by email to central.west.sao@ontario.ca by June 6, 2019.
Please ensure that the written plan does not contain any personal information (PI) or personal health information (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. Resident #015 and resident #017 shared that they were bathed in the tub room that had two tubs in the room. They expressed that when they were bathed, there was another resident in the other tub at the same time. They stated that a privacy curtain was used but they could hear the other residents and any interactions that took place.

PSWs #114, #125 and #128 shared that they bathe two residents in the tub room at the same time with a privacy curtain separating the area.

The tub room was observed and it was noted that the privacy curtains in the tub room were coming off the hooks. There was also ceiling lift tracking that prevented the privacy curtains from closing. The curtains were observed on some occasions not to be fully closed and they hung leaving a gap of approximately 15 cm, on other occasions they were held together by one or two office clips.

ADOC/RAI Coordinator #103 shared that they ask residents on admission if they would mind being bathed when another resident was in the tub because on a previous inspection a resident had told an inspector that they felt like an inmate while being bathed. PSW #114 shared that after the last inspection the home stopped bathing two residents in the tub room at the same time for a short time but had resumed the practice using privacy curtains.

Resident #037 who had the cognitive ability to express their right to privacy during bathing was afforded a bath with no other residents in the tub room.

The licensee failed to ensure that the resident's right to be afforded privacy when bathing/showering was fully respected and promoted for every resident. [s. 3. (1) 8.]

The severity of this issue was determined to be a level 1 as there was no harm/risk to the residents. The scope of the issue was a level 3 as it related to all residents in the home. The home had a level 3 compliance history as this was previously issued as a voluntary plan of correction (VPC) on August 29, 2018 (2018_742527_0012). (155)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 04, 2019

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:** 002

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

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must be compliant with s. 6.(7) of the LTCHA.

Specifically, the licensee must:
a) Ensure that the care set out in the plan of care related to falls prevention is provided to resident #005, #032 and any other resident in the home, as specified in their plan.

b) Ensure that an auditing process is developed and fully implemented to ensure that the plan of care for residents at moderate or high risk for falls is being provided to the residents as specified in their plans. This auditing process must be documented and include the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The audit shall be kept available in the home.

**Grounds / Motifs :**

1. a) Resident #005 had a fall. They were assessed by registered staff and the plan of care was updated to include the use of identified devices as a fall prevention intervention.

Resident #005 was observed on three different occasions during this inspection and only one device was in use.

PSWs #107, #108, and #113 stated that resident #005 had one device in place.

RN #109 reviewed resident #005's plan of care and acknowledged that not all of the devices were in place as specified in their plan of care.

The licensee has failed to ensure that the care set out in the plan of care was provided to resident #005 as specified in the plan.

b) On an identified date, resident #032 was observed hanging off the edge of their bed with the bed being in the highest position. They were calling for help and their alarm was ringing. PSW #119 went in to assist the resident and lowered their bed to the floor.

The clinical records of resident #032 indicated that they were at risk for falls. They had a high-low bed in place and their written care plan directed staff to keep their bed in the lowest position.

PSW #119 and RN #133 stated that resident #032's bed should always be in the lowest position as they were at risk for falling.

PSW #119 acknowledged that on the identified date, resident #032's bed was not in the lowest position as directed by their plan of care.(696) [s. 6. (7)]

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 2 as it related to two of four residents reviewed. The home had a level 3 compliance history that included: voluntary plan of correction (VPC) February 22, 2017 (2017_414110_0002); VPC November 24, 2017 (2017_641513_0014); VPC August 28, 2018 (2018_742527_0013) VPC August 29, 2018 (2018_742527_0012) and VPC September 11, 2018 (2018_742527_0019).
(696)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 04, 2019

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) (a)

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, 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
(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).

**Order / Ordre :**

The licensee must be compliant with s. 6.(11)(b) of the LTCHA.

Specifically, the licensee must:

a) Ensure that when resident #005, #007 and any other resident falls, that different fall prevention approaches are being considered and documented in the revision of the plan of care, when care set out in the plan has not been effective.

**Grounds / Motifs :**

1. a) The clinical records of resident #005 were reviewed and revealed that they had three falls during a twenty-three day period. The resident was re-assessed after each fall but there was no documentation to indicate that different fall prevention interventions were considered in the revision of the plan of care.

The resident's written plan of care did not identify any new approaches or fall prevention interventions that were considered and tried between the specified time period.

A Critical Incident (CI) report was submitted by the home stating that resident #005

had a fall three days later, resulting in an injury.

RN #109 stated that it was an expectation that the resident was assessed after each fall and different approaches were considered in the revision of the plan of care. They acknowledged that different approaches were not considered for resident #005, when the fall prevention interventions in place were ineffective.

b) The clinical records of resident #007 revealed that they had three falls during a three day period. They were assessed after each fall but there was no documentation to indicate that different fall prevention interventions were considered in the revision of the plan of care.

A CI report was submitted to the Ministry of Health and Long Term Care (MOHLTC) stating that resident #007 had a fall on day three of the identified period, resulting in an injury.

The home's policy "Falls Prevention" with a revision date of January 2015, directed registered staff to complete an assessment post fall and to consider interventions with the multidisciplinary team.

DOC #101 acknowledged that different approaches were not considered for resident #007 when the fall prevention interventions in place were ineffective. [s. 6. (11) (b)]

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to two of the three residents reviewed. The home has a level 2 compliance history as there are previous non-compliances, none of which are to the same section/subsection being cited.
(696)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 21, 2019

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)

**Linked to Existing Order / Lien vers ordre existant:** 2018_742527_0012, 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 complaint with s. 8.(3) of the LTCHA.

Specifically the licensee must:
a) 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.

**Grounds / Motifs :**

1. The licensee failed to comply with compliance order #001 from inspection # 2018_742527_0012 issued on August 29, 2018, with a compliance due date of September 17, 2018.

The licensee was ordered to be complaint with s. 8.(3) of the LTCHA.
Specifically the licensee must:
a) 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 is on duty and present in the home at all times, except as provided for in the regulations.

The licensee failed to complete step a). The licensee failed to comply with s.8(3) of the LTCHA.

Review of the registered staff schedules from October 18, 2018 to March 28, 2019 was completed.

The review showed that agency Registered Nurses (RN) worked a total of 16 shifts during this period.

The schedules also showed that there was no RN on duty and present in the home form 1400 to 2200 hours on an identified date. The shift was worked by two Registered Practical Nurses (RPN).

Staff schedules were reviewed with the Office Manager #104. The Office Manager reviewed the agency schedules and agreed that the above dates were worked by agency RNs except for the identified shift that was worked by two RPNs.

During an interview with Director of Care #101, they shared that they used agency RNs when they were not able to staff with their own Registered Nurse. They shared that if an agency RN was working in the home, the home had their own Registered Practical Nurse working in the building. DOC #101 shared that it was their understanding that if they had their own RPN working in the home with the agency RN that it was okay.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it related to all residents in the home. The home had a level 5 compliance history as this was a re-issued compliance order to the same section of the LTCHA that included: compliance order (CO) #001 issued August 29, 2018, with a compliance due date of September 17, 2018 (2018_742527_0012).

(155)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 21, 2019

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:** 005

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

**Linked to Existing Order / Lien vers ordre existant:** 2018_742527_0012, CO #002;

**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 :**

**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

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

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA s.15.(2)(a) to ensure the home, furnishings and equipment are kept clean and sanitary, specifically:

a) Review the schedule for the cleaning of resident #008 and other resident's wheelchairs and develop and implement an action plan to ensure that the resident's wheelchairs are cleaned as per the schedule. The action plan is to include how this will be done and who is responsible to ensure it is implemented in the home.

b) Develop and implement an action plan, including weekly audits and the person(s) responsible for completing the audits, to ensure that the walls, floors, baseboards, raised toilet seats, commodes, windows, window ledges, window screens, wall mounted fans, ceiling fans, ceiling vents, ceilings, vents, and furniture in the home are kept clean and sanitary.

c) The plan shall include how any concerns or deficiencies identified in the audits will be monitored, analyzed, and evaluated to improve the cleanliness of the home.

Please submit the written plan for achieving compliance for inspection 2019_773155_0007 to Sharon Perry, LTC Homes Inspector, MOHLTC, by email to central.west.sao@ontario.ca by June 6, 2019.
Please ensure that the written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. The licensee failed to comply with compliance order #002 from inspection # 2018_742527_0012 issued on August 29, 2018, with a compliance due date of September 28, 2018.

The licensee was ordered to be complaint with s.15.(2) (a) of the LTCHA.
Specifically the licensee must:
a) Ensure that residents #006, #010 and #016, and any other resident , have their wheelchairs kept clean and sanitary.
b) Ensure there is a schedule to clean resident #006, #010 and #016's wheelchairs

and there is documentation maintained of the wheelchairs being cleaned.

The licensee completed step b) in CO #002.
The licensee failed to complete step a) regarding all residents having their wheelchairs kept clean and sanitary.

a) Resident #008's wheelchair was observed during the course of inspection for a ten day period, and the same stain was noted on their cushion.

The document tilted, "Monthly Equipment Cleaning Schedule for TW1 and TW2" indicated that resident #008's wheelchair was scheduled to be cleaned weekly on an identified day and it was documented that it was last cleaned on a specific date.

PSWs #113, #119, and #127 stated that the residents' wheelchairs were scheduled to be cleaned on weekly basis during the night shift but it was all staff's responsibility to keep the wheelchair clean and sanitary.

Director of Recreation #138 stated that they were responsible for creating the cleaning schedule and would look at it on a daily basis to ensure that staff were signing off on it. They added that there was no formal process in place to ensure that the wheelchairs were being cleaned by the staff as directed. They acknowledged that resident #008's wheelchair was not cleaned and that the staff assigned had just signed off on the schedule without completing the task.

The licensee has failed to ensure that resident #008 had their equipment, specifically wheelchairs, kept clean and sanitary.

b) Flooring in the home, specifically in six identified resident rooms, snoozelin room, tub room, shower room, library, and hallways was observed to be dirty and stained during this inspection. The floor between the two back exit doors on Trillium and Poppy Lane units had cobwebs and bugs on them.

Housekeeping staff #135 stated that they mop the floors daily however, buffing of the floors had not been completed since December 2018.

The home's policy "Spray Buffing Floors-Housekeeping" with the revision date of September 2015, directed housekeeping staff to buff the floors monthly for high

traffic areas and quarterly for moderate traffic areas.

The Director of Dietary Services (DDS) #143, the designated lead for housekeeping services, acknowledged that flooring in the home was dirty and stained. They added that the home's Executive Director was aware of this and had brought it to their attention.

c) On three identified days, it was observed that the raised toilet seats, in five resident rooms, were soiled and stained. Also, a commode sitting outside of an identified resident room was observed to be dirty and had dust on it.

Housekeeping staff #135 and #137 stated that they were responsible for cleaning toilets, commodes, and raised toilet seats on a daily basis.

DDS #143 acknowledged that the toilet seats and commodes in the specified rooms should have been cleaned. They added that PSWs were also responsible for cleaning up the toilets after they had toileted a resident.

d) During this inspection, it was observed that the insides of the window panes in six resident rooms and library were dirty. There were cobwebs, leaves, dead insects, soil, and dust present.

Housekeeping staff #137 stated that insides of the windows were usually cleaned for one room on a weekly basis. They agreed that the window panes in and identified room were dirty.

The home's policy "Window Washing-Inside-Housekeeping" last revised on December 2017, directed housekeeping staff to clean inside of the windows on an annual basis or more frequently as required to prevent soil build up and to allow for a bright, clean appearance.

DDS #143 stated that the outside of the windows and window screens were cleaned once a year however, there was nothing in place to keep the insides of the windows clean. They added that they were trying to find something that they could use to clean the insides of the window on a daily basis. They acknowledged that the insides of the windows were dirty and were not being cleaned by staff.

e) During this inspection, it was observed that the ceiling fan in the library; wall mounted fans in the tub room and hallways were dusty and dirty. Also the ceiling vents in the shower room, tub room, and hallways were dusty.

Housekeeping staff #135 and DDS #143 stated that the fans and vents were to be cleaned on a daily basis. However, housekeeping staff #137 said that they were cleaned monthly.

The home's policy "Rotational Cleaning-Housekeeping" last revised January 2015, directed housekeeping staff to dust all vents on a monthly basis.

DDS #143 acknowledged that the ceiling fans, wall mounted fans and vents were dusty. They stated that housekeeping staff were only wiping the ceiling fans and wall mounted fans down from the outside, however now maintenance would inspect and clean them on weekly basis. They stated that this was not being done earlier and was something new that was being implemented.

DDS #143 confirmed that there was no plan in place to clean and inspect the ceiling vents. They were unaware of when the vents were last cleaned.

f) On three identified days, cobwebs were noted under the chair in an identified resident room, under the ceiling fan in the library, on the window in an identified resident room, and on the baseboard in another identified resident room by the doorway.

The home's policy "Rotational Cleaning-Housekeeping" with a revision date of January 2015, directed housekeeping staff to dust window ledges, baseboards, walls, and furniture and to check for any cobwebs on monthly basis.

DDS #143 acknowledged that cobwebs should not have been present in the specified rooms. They stated staff should have been checking for cobwebs and dusting as it was part of their schedule.

During this inspection, a tour was conducted along with DDS #143 to show them the identified housekeeping deficiencies and they acknowledged that the deficiencies existed.

g) On two identified days, it was observed that ceiling in five resident rooms and library were dirty and had stains on them. Also, stains were noted on the wall in a resident room.

The home's policy "Housekeeping cleaning Frequency Schedule" with a revision date of January 2015, directed housekeeping staff to clean walls and ceilings in residents' rooms and common areas on monthly basis.

During an interview with DDS #143, they were unsure of when the walls and ceilings in the home were last cleaned. They were unable to provide the cleaning schedule for it. They said it was their expectation that staff were checking for any spots or stains on the walls and ceilings on daily basis and cleaning them immediately. The acknowledged that ceilings and walls should have been cleaned.

h) During this inspection, it was noted that chairs at both nursing stations were dirty. There was dried up mud present on the legs and bases of the chairs.

The home's policy "Housekeeping cleaning Frequency Schedule" with a revision date of January 2015, directed housekeeping staff to clean office chairs at the nursing station on a weekly basis.

DDS #143 stated that housekeeping staff were responsible for cleaning the floors at the nursing station, however, they were unaware of any schedule or process that was in place to clean the furnishings at the nursing station. They acknowledged that chairs were dirty and process should have been implemented to clean them.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as it related to all residents in the home. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of the LTCHA that included: compliance order (CO) #002 issued August 29, 2018, with a compliance due date of September 28, 2018 (2018_742527_0012).
(696)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 04, 2019

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 :**

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)(c) of the LTCHA.

The licensee shall prepare, submit and implement a plan for achieving compliance with LTCHA s.15.(2)(c) to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, specifically:

a) Develop and implement an action plan to address the following:
-scratch marks on the walls, railings, and baseboards in the hallways, in the identified rooms and any other resident home areas;
-holes in the wall of an identified room and any other resident home areas;
-paint peeling off walls in the hallways, in identified rooms, from the ceiling in an identified room, snoozelin room , from the doors in identified rooms, from the closet door in an identified room, and any other resident home areas;
-missing part of the door in an identified room and any other resident home areas;
-metal corner guard and construction material of the wall was exposed in identified rooms, the washroom of an identified room and any other resident home areas,
-baseboards missing in identified rooms, separated baseboard in an identified room and any other resident home areas;

-closet door missing in an identified room, closet door off the hinges in an identified room and any other resident home areas;
- window supports coming off in an identified room, window would not shut in an identified room, window frame broken in an identified room and any other resident home areas;
-privacy curtains coming off in identified room, tub room, shower room and any other resident care areas;
-lifted floor tiles in washroom and room identified, missing floor tiles in an identified room and Trillium nursing station, cracked floor tiles in identified rooms and any other resident care areas.

b) The action plan must include an auditing process that is developed and fully implemented to ensure that deficiencies of the home, furnishings and equipment are identified. The plan must include an auditing process that must be documented and include the names of the people conducting the audits and the areas that will be audited.

c) The plan shall include how any concerns or deficiencies identified in the audits will be monitored, analyzed, and evaluated to improve that the home, furnishings and equipment. The audits shall be documented and kept in the home.

Please submit the written plan for achieving compliance for inspection 2019_773155_0007 to Sharon Perry, LTC Homes Inspector, MOHLTC, by email to central.west.sao@ontario.ca by June 6, 2019.
Please ensure that the written plan does not contain any PI/PHI.

**Grounds / Motifs :**

1. a) On an identified day, it was noted that counter tops in most of the residents' washrooms were painted white. The paint was peeling off from the counter tops in six resident washrooms and green material was exposed underneath.

A review of home's maintenance care indicated that requests had been sent to maintenance staff, informing them of the counter tops requiring paint in ten identified resident washrooms.

The home's policy, "Work Order Requisitions" with a revision date of January 2015,

directed all staff to send in an electronic requisition for any maintenance related concerns and the Environmental Services manager or designate to review all the work requisitions on daily basis.

DDS #143 stated that it was an ongoing issue and the counter tops should never have been painted white in the first place. They stated that they had brought their concerns forward several times to the previous maintenance lead but nothing was done to fix it. They acknowledged that they were aware that the counter tops in the resident's washrooms were not in good state of repair.

b) During the course of this inspection, the following areas of concerns were identified:

-There were scratch marks on the walls, doors, railings, and baseboards in the hallways and in five identified resident rooms. There were also holes in the wall of an identified resident room.

-The paint was peeling off the walls in the hallways, doors, resident rooms, from the ceiling in an identified resident room, snoozelin room, and from the closet doors.

-A part of the door was missing in a resident room. The metal corner guard and construction material of the wall was exposed in five identified resident rooms and in a resident washroom.

-The baseboards were missing in four resident rooms and was separated in another resident room.

-The closet door in a resident's room was missing and the closet door in another resident room was off the hinges.

-One of the supports on the window in a resident room was coming off. The window in another resident room would not shut completely and the window frame in another resident room was broken.

-The privacy curtains were coming off the tracks in an identified resident room, tub room, and shower room.

The home's policy "Preventative Maintenance Task Schedule" last revised on November 2017, directed maintenance staff to complete resident room inspection on a quarterly basis. The inspection included painting, plumbing, safety, maintenance, hardware, and wall finishes. Each room was to be inspected at least twice a year.

The home's maintenance binder was reviewed and there was no documentation to indicate that all rooms were inspected in 2018.

The Environmental Services Manager (ESM) #145 from Owen Hill Care Community during their tour of the home along with DDS #143, identified maintenance issues like wall damage, missing baseboards, paint peeling off, and closet doors missing, misaligned, or coming off. They said that if maintenance and housekeeping were doing their daily audits then it should never come to this.

DDS #143 stated that they were unsure if all residents' rooms and hallways were being inspected as required. They said there was no maintenance aid present in the home during an identified week during the inspection. They added that they had no previous experience with maintenance services and had not been doing any audits for maintenance. They acknowledged that home's walls, doors, windows, ceilings, closet doors, and baseboards were in disrepair and should have been dealt with on regular basis.

c) During this inspection, it was noted that the tiles in the washroom of an identified resident room were lifting off. There were missing tiles in an identified resident room and Trillium nursing station and cracked tiles in three identified resident rooms.

RN #109 stated that tiles in the nursing station had been missing for a few years and maintenance was well aware of this.

During an interview with DDS #143, they stated that they were aware that the flooring in the specified areas was in poor condition. They acknowledged that maintenance requests were sent for these issues but nothing was put in place to rectify these concerns.

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

## 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

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it related to all residents in the home. The home had a level 3 compliance history that included a written notification (WN) August 29, 2018 (2018_742527_0012). (696)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Feb 14, 2020(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:** 007

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

**Linked to Existing Order / Lien vers ordre existant:** 2018_742527_0013, CO #001;

**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) of the LTCHA.

Specifically, the licensee must:

a) Ensure that resident #037 is protected from abuse by residents #023 and #038.

b) Ensure that all residents are protected from neglect by staff.

c) Ensure that when there is a change in a resident's condition, staff provide the timely treatment, care, services and assistance required for the health, safety or well-being of the resident.

**Grounds / Motifs :**

1. The licensee failed to comply with compliance order #001 from inspection # 2018_742527_0013 issued on August 28, 2018, with a compliance due date of September 7, 2018.

The licensee was ordered to be complaint with s. 19.(1) of the LTCHA.
Specifically the licensee must ensure:
a) Residents #002, #003, #004 and any other residents are protected from sexual abuse by resident #001.
b) Develop and implement a written weekly audit to be conducted over the next three

months to ensure monitoring and documentation as per the plan of care for resident #001.

Resident #001 was no longer in the home. The licensee failed to comply with s. 19. (1) of the LTCHA.

The licensee has failed to ensure that resident # 037 was protected from abuse by anyone.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

A progress note, stated that resident #037 reported that on two occasions other identified residents had made remarks of a sexual nature towards them. This conversation was witnessed. Eighteen days later, resident #037 reported another incident of a sexual nature by the same identified residents.

Record review of resident #023 revealed that there was a documented incident of a sexual nature towards resident #038.

An assessment for resident #023 was initiated on an identified date, but had not been completed or finalized.

A Referral Form was completed and faxed for resident #023 after the incident, however, no further documentation could be located.

In an interview, resident #037 stated that they recalled the two events and were very upset.

The licensee failed to ensure that resident # 037 was protected from abuse by anyone. [s. 19. (1)] (539)

2. 2. The licensee failed to ensure that residents were not neglected by the licensee or staff.

For the purposes of the Act and this Regulation, "neglect" means the failure to

provide a resident with the treatment, care, services, 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.

a) Resident #008's clinical records identified that they had a fall on an identified date.

The next morning, resident #008 was observed sleeping in their bed and there were areas of altered skin integrity noted. The call bell at their bed side was not working..

Two PSWs shared that the call bell in resident #008's room had been broken and they had reported it. They stated that resident #008 relied on their call bell.

Resident #008's care plan revealed that they were able to ask for assistance from staff.

There was no documentation to indicate that any interventions were put in place to closely monitor the resident while the call bell was not functioning prior to the fall.

ADOC #102 stated that they were aware that resident #008's call bell was broken however no actions were taken by them to ensure that resident #008 had something in place so that they could call for assistance when needed.

During an interview with DOC #101 they acknowledged that this was considered neglect as no action was taken by the home to fix resident #008's call bell and they subsequently fell.

The licensee has failed to ensure that resident #008 was not neglected by the licensee or staff.

b) A complaint was reported to the MOHLTC regarding an allegation of neglect by staff towards resident #013.

Resident #013's progress notes showed that Registered Nurse (RN) #133 documented on an identified date, that the resident had an area of altered skin integrity. Eight entries over ten days in the resident's progress notes stated the

resident had altered skin integrity. Assessments related to skin and wound, pain, vital sign monitoring and communication to the substitute decision maker (SDM) were not completed during the ten day period. There were no interventions put in place to address resident #013's change in condition.

RN #133 and #141 acknowledged that resident #013 did not receive assessments and treatments for the area of altered skin integrity for a ten day period and required hospitalization.

Registered staff #106, #134, ADOC #102 and DOC #101 stated it was the home's expectation that an initial skin assessment would be completed for areas of altered skin integrity. All staff interviewed confirmed that not providing care, assessments or treatments would be considered neglect.

The licensee failed to protect #013 from neglect that jeopardized their health and well-being.

c) A complaint was received by the MOH with an allegation of neglect by staff towards resident #006.

Review of the clinical record for resident #006 showed that for an identified twenty-seven day period resident #006 had a change in condition.

There were no nursing assessments, no documented communication with the physician and no interventions put in place regarding resident #006's change in condition.

The licensee failed to protect #006 from neglect that jeopardized their health and well-being. [s. 19. (1)]

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to four of the seven residents reviewed. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of the LTCHA that included: compliance order (CO) #001 issued August 28, 2018, with a compliance due date of September 7, 2018 (2018_742527_0013). (696)

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 :** Jun 03, 2019

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) (a)

**Linked to Existing Order / Lien vers ordre existant:** 2018_742527_0012, CO #003;

**Pursuant to / Aux termes de :**

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

**Order / Ordre :**

The licensee must be compliant with s.76(2) of the LTCHA.

Specifically, the licensee must:

a) Ensure that RPN #132, RN #146, RN #147, RN #154, RN #155, RN #159 and DOC #101 receive the required training as outlined by this section of the LTCHA.

b) Ensure that records are kept of the training completed in the home.

c) Ensure that each staff member hired by the home and any new agency staff member working in the home are provided training as required by this section of the LTCHA prior to performing their duties. Records of the training completed by each staff member must recorded and available at the home.

**Grounds / Motifs :**

1. The licensee failed to comply with compliance order #003 from inspection # 2018_742527_0012 issued on August 29, 2018, with a compliance due date of September 28, 2018.

The licensee was ordered to be complaint with s. 76 (2). of the LTCHA.
Specifically the licensee must:
a) Ensure that agency Registered Nurse (RN) #153, #154, #155, #156, #157, #158, #159; and agency Registered Practical Nurse (RPN) #103, #160, #161 and #162, as well as any other agency staff and all other staff at the home, do not perform their responsibilities before receiving training in the following areas:

1. The Residents' Bill of Rights;
2. The long-term care home's mission statement;
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents;
4. The duty under section 24 to make mandatory reports;
5. The protections afforded by section 26;
6. The long-term care home's policy to minimize the restraining of residents;
7. Fire prevention and safety;
8. Emergency and evacuation procedures;
9. Infection prevention and control;

10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.; and
11. Any other areas provided for in the regulations.

b) The training will be documented and the training records, for agency RN #153, #154, #155, #156, #157, #158, #159; and agency RPN #103, #160, #161 and #162, as well as any other agency staff and all other staff at the home, will be kept in the home.

The licensee failed to complete steps a) and b) in CO #002.

The licensee failed to ensure that RPN #132, RN #146, RN #147, RN #154, RN #155, RN #159 and DOC #101 received training before performing their responsibilities as required by this section.

Office Manager #104 shared that the home continues to use agency RNs, RPNs and PSWs when needed. They stated that the home used three agencies.

During an interview with Office Manager #104, a review of the schedules showed that agency RNs #154, #155 and #159 had worked at the home after the compliance order due date of September 28, 2018.

Review of the home's agency orientation records was done and showed that RN #154, RN #155 and RN #159 signed that they had orientation on identified dates. It was noted on review of the orientation records that RN #154, #155, #159 had not completed orientation to the homes' falls prevention and management, skin and wound care, continence care and bowel management, and pain management programs.

Office Manager #104 acknowledged that the agency orientation binder did not include policies on falls prevention and management program, skin and wound care program, continence care and bowel management program and pain management program.

A review of the schedule showed that agency RN #146 had worked in the home on three identified dates between October 27, 2018 and January 1, 2019. Office Manager #104 was not able to provide agency RN #146's orientation checklist or a

sign off of policies done by this individual. On an identified date, Office Manager #104 provided an orientation checklist that agency RN #146 had faxed the home that day, however, there was no date to indicate when the orientation would have been completed.

RPN #132 was hired on an identified date. During an interview, RPN #132 agreed that they did not complete any education prior to performing their duties regarding the skin and wound care, falls prevention and management, continence care and bowel management and pain management program.

Review of the orientation records showed that RPN #132 had not completed orientation to the skin and wound care, falls prevention and management, continence and bowel management and pain management programs.

RN #147 was hired on an identified date. Review of their orientation records showed that they had not completed orientation on the long-term care home's mission statement, skin and wound care, falls prevention and management, and pain management programs.

DOC #101 started in their role on an identified date. A review of DOC #101's employee file/ orientation package showed that the home's policy to promote zero tolerance of abuse and neglect was signed forty days after they started in their role; and infection prevention and control was signed sixty-two days after they started in their role. A review of DOC #101's Relias transcripts from date of hire to present showed that Privacy and Security and Hazardous Chemicals was completed a total of 0.5 hours.

During an interview with DOC #101 they were not able to provide any information showing that they had orientation/training to the following prior to performing their responsibilities: the Residents' Bill of Rights; the long-term care home's mission statement; the duty under section 24 to make mandatory reports; the protections afforded by section 26; the long-term care home's policy to minimize the restraining of residents; fire prevention and safety; emergency and evacuation procedures; infection prevention and control; and all acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities; and any other areas provided for in the regulations.

**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

During an interview with Assistant Director of Care #102 they shared that they were the designated lead for education in the home. Assistant Director of Care #102 was not able to provide any information on orientation for agency RNs , RPNs and PSWs for the skin and wound care, falls prevention and management, continence care and bowel management and pain management programs.

ADOC #102 shared that registered staff hired by the home had approximately 30 programs in Relias to complete when they were a new hire.

ADOC #102 was not able to provide any education records regarding the skin and wound care, falls prevention and management, continence care and bowel management and pain management program for RPN #132. RPN #132 had completed 15 Relias modules from date of hire.

ADOC #102 was not able to provide any education records regarding the long-term care home's mission statement, skin and wound care, falls prevention and management, and pain management programs for RN #147. RN #147 had completed 12 Relias modules from date of hire.

The severity of this issue was determined to be a level 2 as there was minimal risk to the residents. The scope of the issue was a level 3 as seven out of seven staff had not been trained prior to performing their duties. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of the LTCHA that included: compliance order (CO) #003 issued August 29, 2018, with a compliance due date of September 28, 2018 (2018_742527_0012).
(155)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jan 31, 2020(A3)

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. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,

(a) can be easily seen, accessed and used by residents, staff and visitors at all times;

(b) is on at all times;

(c) allows calls to be cancelled only at the point of activation;

(d) is available at each bed, toilet, bath and shower location used by residents;

(e) is available in every area accessible by residents;

(f) clearly indicates when activated where the signal is coming from; and

(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

**Order / Ordre :**

The licensee must be compliant with s. 17(1)(a) of the O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that the call bell in room 38, the call bell in the washrooms of room 43 and 46 and all other call bells in the home are easily seen, accessed and used by residents, staff and visitors at all times.

b) Ensure an auditing process is developed and fully implemented to ensure that all call bells are functioning. This auditing process must be documented and include the auditing schedule, the names of the people conducting the audit, the rooms that have been audited, the results of the audit and what actions were taken in regards to the audit results.

c) Ensure that there is a process developed and implemented to report and action call bells that have been identified for repair and that all staff are aware of the process and their roles and responsibilities.

**Grounds / Motifs :**

1. a) On an identified date, the call bell cord was missing in the washroom for resident #039.

PSW #127 stated that if a washroom call bell was not functioning it would cause the call bell at the bedside in the same room to not work.

Resident #039 was without a call bell for 18 hours. Staff stated they were to complete checks every 15 minutes if a resident's call bell was not working, but checks were not documented.

b) On an identified date, it was observed that the call bell in the washroom of and identified room was not available.

PSW #113, #127, and #129 stated that resident #026 did not have access to a call bell in their washroom for 2 days. They said that resident #026 relied on their call bell to get staff assistance.

A review of the maintenance care log revealed that a maintenance care request was

sent.

c) On an identified date, it was observed that the call bell between the beds of resident #008 and #040 was not available.

Two PSWs shared that the call bell in resident #008's room had not been available for one day. They stated that resident #008 relied on their call bell.

During an interview with DOC #101 and ADOC #102, they both stated that call bells should always be available for residents at their bedside and in their washrooms.

DDS #143 acknowledged that the call bells were not available for the identified residents. They said that a maintenance requests were sent but they had not been checking the maintenance log daily as required.

The licensee failed to ensure that residents and staff had access at all times to the resident-staff communication response system.

The severity of this issue was determined to be a level 3 as there was actual harm to a resident. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home has a level 2 compliance history as there were previous non-compliances, none of which were to the same section/ subsection being cited. (694)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 21, 2019

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) (a)

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 24. (2) The care plan must identify the resident and must include, at a minimum, the following with respect to the resident:
1. Any risks the resident may pose to himself or herself, including any risk of falling, and interventions to mitigate those risks.
2. Any risks the resident may pose to others, including any potential behavioural triggers, and safety measures to mitigate those risks.
3. The type and level of assistance required relating to activities of daily living.
4. Customary routines and comfort requirements.
5. Drugs and treatments required.
6. Known health conditions, including allergies and other conditions of which the licensee should be aware upon admission, including interventions.
7. Skin condition, including interventions.
8. Diet orders, including food texture, fluid consistencies and food restrictions.
O. Reg. 79/10, s. 24 (2).

**Order / Ordre :**

The licensee must be compliant with s. 24(2)1. of O.Reg 79/10

Specifically, the licensee must ensure that:

a) The plan of care for resident #011 identifies any risk of falling and interventions to mitigate those risks.

b) The 24-hour admission care plan for all new admissions include any risk of falling and interventions to mitigate those risks.

## 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. Resident #011 was admitted to the home on an identified date with a history of falls.

A fall risk assessment was completed upon admission and it identified that resident #011 was at risk for falling.

The clinical records of resident #011 were reviewed and there was no documentation to indicate that any interventions were put in place upon admission to mitigate the resident's risk of falling.

The resident's 24 hour admission care plan did not include their risk of falling and any interventions to mitigate those risks.

After admission to the home, resident #011 had a fall which resulted in injury.

The home's policy "Falls Prevention" policy directed registered staff to complete the Falls Risk Assessment within 24 hours of admission and to update the care plan with associated risk level and interventions.

RPN #123 acknowledged that the resident's 24-hour admission care plan did not include their risk of falling and any interventions to mitigate those risks.

The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope was a level 1 as it related to one of three residents reviewed. The home has a level 2 compliance history as there were previous non-compliances, none of which were to the same section/ subsection being cited. (696)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 21, 2019

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:** 011

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 25. (1) Every licensee of a long-term care home shall ensure that,
(a) the assessments necessary to develop an initial plan of care under subsection 6 (6) of the Act are completed within 14 days of the resident's admission; and
(b) the initial plan of care is developed within 21 days of the admission. O. Reg. 79/10, s. 25 (1).

**Order / Ordre :**

The licensee must be compliant with s. 25. (1) of O.Reg 79/10.

Specifically, the licensee must ensure that:

a) For all residents admitted to the home, that the assessments necessary to develop the initial plan of care are completed within 14 days of the resident's admission and that the initial plan of care is developed within 21 days of the admission.

b) Ensure an auditing process is developed and fully implemented to ensure that initial assessments and plans of care for residents are completed within the required time period identified in the regulations. This auditing process must be documented including when the audit took place, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken with regards to the audit results.

**Grounds / Motifs :**

1. a) Resident #031 was admitted to the home on an identified date. Review of their Minimum Data Set (MDS) admission assessment, 23 days post admission, showed that 17/20 sections of the assessment were not completed.

Review of the initial plan of care contained no information regarding customary routines; cognition ability; communication abilities, including hearing and language; vision; mood and behaviour patterns; psychological well-being; physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming; continence, including bladder and bowel elimination; dental and oral status, including oral hygiene; skin condition; activity patterns and pursuits; drugs and treatments; sleep patterns and preferences; cultural, spiritual and religious preferences and age-related needs and preferences.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long Term Care on an identified date, for alleged abuse of resident #031 by staff. The initial plan of care did not include the type of assistance resident #031 required for toileting and care requirements regarding continence care.

b) Resident #033 was admitted to the home on an identified date. Review of their MDS admission assessment, 28 days post admission, showed that 14/20 sections of the assessment were not completed.

Review of the initial plan of care contained no information regarding cognition ability; communication abilities, including hearing and language; mood and behaviour patterns; psychological well-being; physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming; continence, including bladder and bowel elimination; dental and oral status, including oral hygiene; skin condition; drugs and treatments; cultural, spiritual and religious preferences and age-related needs and preferences.

c) Resident #020 was admitted to the home on an identified date. Review of their MDS admission assessment, 24 days post admission, showed that 14/20 sections of the assessment were not completed.

Review of the initial plan of care contained no information regarding cognition ability; continence, including bladder and bowel elimination; skin condition; drugs and treatments; cultural, spiritual and religious preferences and age-related needs and preferences.

ADOC/RAI Coordinator #103 agreed that resident #031, #033 and #020 were not

assessed within 14 days of the resident's admission and the initial plan of care was not developed within 21 days of admission.

For residents #020, #031 and #033, the licensee failed to ensure that the assessments necessary to develop an initial plan of care were completed within 14 days of the resident's admission; and the initial plan of care was developed within 21 days of the admission.

The severity of this issue was determined to be a level 2 as there was minimal harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home has a level 2 compliance history as there were previous non-compliances, none of which were to the same section/ subsection being cited. (155)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 04, 2019

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:** 012

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

**Linked to Existing Order / Lien vers ordre existant:** 2018_742527_0012, CO #004;

**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 :**

**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

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

Specifically, the licensee must:

a)Ensure the written staffing plan required for the organized program of nursing services and the organized program of personal support services under clause 8(1) (b) of the Act, provides for a staffing mix that is consistent with residents assessed care and safety needs.

b) Develop, document and implement a process in the home for the leadership to evaluate, at a minimum of bi-weekly, whether the written staffing plan is consistently meeting the residents assessed care and safety needs in the home. This evaluation must include:
i) An analysis of the care and safety needs of each group of residents in each section of the home which includes, but is not limited to, the residents' care needs related to Activities of Daily Living (ADLs) including toileting and continence care; responsive behaviours; assistance with transfers, mobility and positioning; skin and wound care; falls prevention and bathing.
ii) An analysis of whether the written staffing plan for each section of the home, as per the staff assignment sheet, is meeting the care and safety needs of all residents living in the home.
iii) A documented record of the staffing plan evaluation which includes the date it was conducted, the names and signatures of the participants, the information analyzed, the results of the evaluation and what was done with the results of the evaluation.

c) Ensure the evaluation includes analyzing the variances related to vacant registered and PSW positions including the back-up plan.

d) Ensure the revised staffing plan, including the revised staffing back-up plan, is implemented and complied with.

**Grounds / Motifs :**

1. The licensee failed to comply with compliance order #004 from inspection # 2018_742527_0012 issued on August 29, 2018, with a compliance due date of September 28, 2018.

**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

The licensee was ordered to be complaint with O.Reg 79/10 s. 31. (3)(a).
Specifically the licensee must:
a)Ensure that the written staffing plan for the nursing and personal support services programs provide for a staffing mix that is consistent with residents' assessed care and safety needs.

The licensee failed to complete step a). The licensee failed to comply with O.Reg 79/10 s. 31.(3)(a).

Review of the home's staffing plan for PSWs was completed.

During an interview with Staffing Coordinator #139 they shared that the home had four part time PSWs plus two part time PSWs that worked short shifts. The home had one casual PSW and were having to use agency PSWs to assist with covering the PSW shifts.

A review of PSW hours for two 14 day periods was done.

For one period, the home had 272.04 vacant PSW hours.
For another period, the home had 316.80 vacant PSW hours.

Resident #015 and #027 shared that they did not get their bath on an identified date as there was not enough staff. Resident #015 shared that they felt this happened every month.

Six personal care staff expressed that they worked short on a frequent basis. They shared that the bathing/feeding shifts got pulled to work on the floor therefore residents were not getting their bath. When this happened they shared that the direction they were given was to give the residents a bed bath.

On an identified date, the two bathing/feeding shifts from 0600-1400 hours were pulled to work on the floor. This resulted in 13/14 residents not receiving their scheduled baths, but they were given a bed bath instead.

PSW #129 shared that the home was always short staffed and usually ended up working with six PSWs or less in the home instead of the planned eight PSWs. They shared that they did not get residents toileted as much as they needed nor were

baths getting done.

On an identified date, review of the schedule showed that they were short a 0600 to 1400 bathing/feeding shift. PSW #128 shared that as a result of this shortage the residents on the identified list would not receive their bath but were to be offered a bed bath. PSW #128 shared that 8/8 residents were not given their bath.

PSWs #112 and #140 shared that they worked short on two identified dates. They stated that on both dates, they were short two PSWs from 1400-2200 hours, a PSW from 1700-2100 hours and two bathing/feeding shifts that work 1100-1900 and 1130 to 1930 hours. The 1700-1900 shift was never covered on identified weekends. PSW #112 expressed that they were not able to provide all the care the residents required. During these two identified dates 14/23 residents did not receive their bath/shower.

On an identified date, Inspector 694 observed resident #016 asking RPN #148 to go to bed. RPN #148 informed resident #016 that they would have to wait 30 minutes as staff were busy in the dining room. Review of the staffing for this date was done and PSW #107 shared that they worked short two PSWs from 0600-1400 hours. Resident #016 shared that they wanted to go to bed because they were uncomfortable. The schedule and PSWs #112 and #140 confirmed that they were working with one less PSW from 1400-2200.

Review of the home's staffing plan evaluation provided by DOC #101 on March 26, 2019 was completed. The home's staffing plan was last evaluated on January 4, 2018 and included goals and objectives for 2018.

When DOC #101 was asked if the staffing mix was consistent with the residents' assessed care and safety needs they shared that they had worked as a PSW and stated that PSWs just have to expend more energy to get the work done.

The licensee failed to ensure that the written staffing plan for the nursing and personal support services programs provided for a staffing mix that was consistent with residents' assessed care and safety needs. The licensee failed to ensure that the staffing plan was evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

## 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

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it relates to all residents residing in the home. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of O.Reg 79/10 that included: compliance order (CO) #004 issued August 29, 2018, with a compliance due date of September 28, 2018 (2018_742527_0012).
(155)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Jan 31, 2020(A3)

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:** 013

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

**Linked to Existing Order / Lien vers ordre existant:** 2018_742527_0012, CO #005;

**Pursuant to / Aux termes de :**

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

**Order / Ordre :**

The licensee must be compliant with s. 33. (1) of O.Reg 79/10

Specifically, the licensee must:

a) Ensure that residents #008, #015, #027 and all residents are provided bathing by the method of their choice at a minimum twice per week.

b) Ensure that there is a process in place that tracks the residents' bathing preference, by which method they were bathed and when they were bathed.

c) Ensure that an auditing process is developed and fully implemented to ensure that residents are being bathed by the method of their choice. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken with regards to the audit results.

d) Ensure that residents whose preferred method of bathing is a shower, that they are provided a shower in a functional and accessible shower area.

## 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 failed to comply with compliance order #005 from inspection # 2018_742527_0012 issued on August 29, 2018, with a compliance due date of September 28, 2018.

The licensee was ordered to be complaint with O.Reg 79/10, s.33.(1).
Specifically the licensee must:
a) Ensure residents #014, #015, and #019 have been bathed , at a minimum, twice a week by the method of their choice and that it is documented in point of care.

The licensee failed to complete step a) in CO #005. The licensee failed to compy with s.33.(1) of O.Reg 79/10.

During interviews three PSWs shared that the bathing/feeding PSW would get reassigned to work a floor assignment if they were short three PSWs on the floor. They said that the direction they had been given when that happened was that the residents that were assigned to the bathing/feeding PSW were to be given bed baths by their assigned PSW.

PSW #127 shared that resident #008 had expressed concern to them that they had gone a week without getting a bath. PSW #127 shared that on an identified date, resident #008 was to get a bath however the bathing/feeding shift was not filled and resident #008 was given a bed bath.

Further review of POC documentation and schedules also indicated that resident #008 did not receive their bath preference on another identified date.

Review of day baths for two identified dates and afternoon/evening baths for two identified dates showed that 35/45 residents (77 per cent) did not get bathed by their method of choice.

During an interview with Director of Care #101 they shared that if the bathing/feeding shift was reassigned to the floor then those assigned residents would get bed baths. They stated that their was no way of knowing when residents were given a bed bath instead of their bath preference.

3. Resident #027 shared that on an identified date, they did not get their bath and were given a bed bath. Resident #027 also expressed that if the home had a shower area where they could sit in a shower chair their preference would be a shower.

Review of POC documentation for resident #027 showed that staff were not able to document the type of bath that was provided to resident #027 but only able to comment on the amount of self performance and support provided. Review of POC documentation for the identified date and interviews with PSW #128 supported that they gave resident #027 a bed bath and not a tub bath.

PSW #114 shared that the only shower area in the home was located in Tub Room A and only residents that walked could go in the shower.

DOC #101 shared that they were not aware of how residents who could not ambulate were being showered in the home.
(155)

2. During an interview resident #015 they shared that on an identified date, they did not get a tub bath but received a bed bath because there was no staff available to give tub baths. They expressed that this happened approximately once a month.

There was no documentation to support that resident #015 was bathed by the method of their choice. (155)

3. Resident #027 shared that on an identified date, they did not get their bath and were given a bed bath. Resident #027 also expressed that if the home had a shower area where they could sit in a shower chair their preference would be a shower.

Review of POC documentation for resident #027 showed that staff were not able to document the type of bath that was provided to resident #027 but only able to comment on the amount of self performance and support provided. Review of POC documentation for the identified date and interviews with PSW #128 supported that they gave resident #027 a bed bath and not a tub bath.

PSW #114 shared that the only shower area in the home was located in Tub Room A and only residents that walked could go in the shower.

DOC #101 shared that they were not aware of how residents who could not ambulate were being showered in the home.

The licensee failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of O.Reg 79/10 that included: compliance order (CO) #005 issued August 29, 2018, with a compliance due date of September 28, 2018 (2018_742527_0012). (155)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jul 15, 2019(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

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**Order # / No d'ordre:** 014

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

**Order / Ordre :**

The licensee must be compliant with s. 50(2)(b)(i) and (iv) of O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that all residents that exhibit altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment.

b) Ensure that resident #005, #011 and all residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

c) Ensure that an auditing process is developed and fully implemented to ensure that residents with impaired skin integrity are being assessed as provided for in the regulation. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken with regards to the audit results.

**Grounds / Motifs :**

1. The clinical record for resident #013 was reviewed and Registered Practical Nurse (RPN) #124 identified that resident #013 had an area of altered skin integrity. A progress note was made on an identified date regarding the altered skin integrity.

RPN #124 and ADOC #102 acknowledged that resident #013 did not have a Skin and Wound Care Assessment completed when the area of altered skin integrity was identified.

The licensee failed to ensure that resident #013 had a skin assessment completed by a member of the registered staff when they had altered skin integrity. (694)

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

a) Resident #011 was admitted to the home on an identified date with an area of altered skin integrity.

The clinical records of resident #011 were reviewed and there was no weekly skin assessment completed for their altered skin integrity.

RPN #123 stated that they were aware that resident #011 was admitted with an area of altered skin integrity. RPN #123 acknowledged that the area of altered skin integrity had not been reassessed weekly by registered nursing staff since admission four weeks ago.

b) Resident #005 sustained an area of altered skin integrity after an incident.

The clinical records for resident #005 were reviewed and there was only one skin assessment that was completed.

There was no other documentation to indicate that staff had completed weekly skin assessments for the area of altered skin integrity for five weeks.

RN #109 stated that after a new skin issue was identified, registered staff were expected to do a weekly skin assessment until the skin issue had been resolved. They reviewed the weekly skin assessments for resident #005 and acknowledged that the registered staff did not complete any weekly skin assessments for resident #005.

RN #109 stated that the area of altered skin integrity was healed however there was no documentation to indicate when it healed.

c) RPN #124, RN #133, RPN #134, ADOC #102 and DOC #101 acknowledged that when residents experience altered skin integrity, registered staff were expected to complete an initial wound and treatment assessment in Point Click Care (PCC), then conduct weekly skin reassessments and document in the progress notes.

Resident #013 had an area of altered skin integrity first documented in the progress notes on an identified date. There were no weekly assessments completed during a 10 day period.

## 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

The licensee failed to ensure resident #005, #011 and #013 who were exhibiting altered skin integrity had been reassessed at least weekly by a member of the registered nursing staff.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 3 as it related to three of three residents reviewed. The home had a level 3 compliance history that included: voluntary plan of correction (VPC) issued November 24, 2017 (2017_641513_0014). (696)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d’ici le :** Jun 21, 2019

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:** 015

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

**Linked to Existing Order / Lien vers ordre existant:** 2018_742527_0013, CO #002;

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

**Order / Ordre :**

The licensee must be compliant with s. 53(4)(b) and (c) of O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that the strategies that are developed to respond to the behaviours of resident #010, #014, #017 and any other residents with responsive behaviours are implemented.

b) Ensure that actions are taken to respond to the needs of resident #014, #017, #030, #023, #038, #001 and any other resident exhibiting responsive behaviours, including assessments, reassessments and interventions and that the resident's responses to interventions are documented.

c) Ensure that registered staff are provided training regarding the referral process to BSO, completion of behavioural assessments and implementation of interventions, and that there is a process developed and implemented to monitor and ensure that actions are taken by registered staff to respond to the needs of residents exhibiting responsive behaviours.

## 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 failed to comply with compliance order #002 from inspection # 2018_742527_0013 issued on August 28, 2018, with a compliance due date of September 7, 2018.

The licensee was ordered to be complaint with O.Reg 79/10, s.53.(4)(b).
Specifically the licensee must:
a) Ensure that staff providing one to one monitoring and staff that provide direct care to resident #001, implement the responsive behaviour plan of care and document the strategies implemented and the effectiveness of the responsive behaviour strategies.
b) Ensure that staff providing one to one monitoring and staff that provide direct care to resident #001, receive training on the resident's responsive behaviour plan of care; one to one monitoring and documentation of the staff trained and the training content provided to direct care providers.

The licensee completed step b) in CO #002.
Resident #001 was no longer in the home. The licensee failed to comply with O.Reg 79/10 s. 53.(4) (b).

1. The licensee has failed to ensure that strategies had been developed and implemented to respond to the resident demonstrating responsive behaviours.

a) At the beginning of the home's inspection, three residents verbalized that they were very unhappy, and discussed the behaviours of two residents.

PSW #136 stated that resident #014 and resident #017 had an identified behaviour, however, they were not harming anyone by doing this.

Progress notes stated that:

On eight occasions during a nine week period, resident #014 and #017 had an identified responsive behaviour.

On five other occasions during a six week period, resident #017, had other identified responsive behaviours.

Circle of Care meeting minutes identified strategies for some of the responsive behaviours.

On numerous occasions during the inspection the identified strategies were not in place and resident #014 and #017 were observed having responsive behaviours.

The Internal Responsive Behaviour Protocol for Creedan Valley Care Community, instructed staff to update the care plan to include descriptions of cues and triggers, what the escalation would look like, interventions, patterns, environmental risk factors or conditions.

Resident #014 and #017's care plan did not identify the above behaviours or strategies to address the behaviours.

PSW #136 and RPN #130 stated that strategies were not always implemented by staff. RPN #130 stated the home was behind in updating the care plans with behavioural strategies.

b) Resident #014 and #017 were observed on multiple occasions during the inspection.

Resident # 014's care plan had identified an intervention, as recommended by the BSO team.

During the inspection the identified intervention was not observed to be implemented.

RPN #130 stated staff were not consistent in implementing responsive behaviour strategies.

c) During this inspection, resident #010 described how two residents had responsive behaviours.

Progress notes showed that the resident made the home aware of their frustration with identified residents.

The home submitted a Critical Incident, regarding an altercation between two

identified residents.

Resident #010's care plan did not provide strategies to staff.

The "Internal Responsive Behaviour Protocol for Creedan Valley Care Community" stated that care plans should be updated with changes, and should include descriptions of cues and triggers, what the escalation would look like, interventions, patterns, and environmental risk factors or conditions.

Circle of Care minutes stated that the home would ensure that two strategies were implemented in response to the responsive behaviours.

On multiple observations throughout the inspection these strategies were not implemented.

Resident #010 stated that they were frustrated.

PSW #136 and RPN #130 stated that interventions were not always in place to address resident #010's responsive behaviours.

The licensee has failed to ensure that strategies had been developed and implemented for resident's #010, #014 and #017 responsive behaviours. [s. 53. (4) (b)] (539)

2. The licensee failed to ensure the actions taken to meet the needs of the resident with responsive behaviours included assessment, reassessments, interventions, and documentation of the resident's responses to the interventions.

1. a) Progress notes from an identified month, for resident #030 documented how the resident had certain identified behaviours.

On an identified date, resident #030 had a change in treatment.

The doctor ordered the staff to monitor. Record review did not provide any documentation of the monitoring.

Resident #030 sustained a fall 20 days after the change in treatment.

There was no documentation of resident #030's responses to the interventions as ordered by the physician.

b) A Behaviour progress note documented that resident #030 was having increased physical behaviours and a referral was made to the BSO.

Upon review of resident #030's record, an electronic Responsive Behavioural Referral to the internal BSO Lead, and a completed DOS, could not be located for this time period.

RPN #130 stated that a DOS was only completed when ordered by the doctor and the BSO referral only continued when decided upon by the management team.

ADOC #103 was unable to locate an electronic Responsive Behavioural Referral and completed DOS notes for resident #030.

c) The home submitted a Critical Incident report was submitted when resident #030 sustained a injury.

During multiple observations, resident #030 was observed with responsive behaviours.

Six progress notes during a two week period, documented continued responsive behaviours toward staff.

The care plan under behaviours identified an approach to dealing with the resident's responsive expressions.

PSW # 136 stated the behaviour had gotten progressively worse since resident #030 had sustained the injury.

RPN #130 stated resident #030 was not being monitored for responsive behaviours.

ADOC #103 was unable to locate a BSO electronic referral, completed DOS notes, or assessment for resident #030.

2. A progress note completed by ADOC #103, stated resident #037 informed them

on an identified date that resident #023 and #038 had responsive behaviours that bothered them very much.

Resident # 023 was known to staff to have responsive behaviours.

An electronic Responsive Behaviours Assessment for resident #023 was initiated ion a specific date, but had not been completed or finalized.

A DOS was started, however, the form was incomplete.

A Referral Form was completed and faxed for resident #023 after the incident, however, no further documentation could be located in the BSO binder, the circle of care meeting minutes or the resident's chart.

The home's policy entitled, Sexual Expression & Intimacy, policy # VII-G10.02, last revised December 2017, stated that upon becoming aware of a resident's sexual expression, the residents should be assessed using the Lichtenburg Tool for Assessing Sexual Capacity to Consent, and a MMSE be completed.

DOC #101 stated that the home had not considered the behaviour of resident #023 and #038 towards resident #037 inappropriate due to their cognitive status.

3. A Critical Incident report was submitted that regarding alleged abuse between resident #001 and resident #002.

The Interdisciplinary Care Conference summary, for an identified date, for Minimum Data Set (MDS), stated that the resident's aggressive behaviour score (ABS) had worsened.

Review of the progress notes from the time of the Interdisciplinary Care Conference summary until present described how resident #001's behaviours increased.

PSW #107 was unaware that resident #001 had been assessed by the BSO team.

RPN #106 described resident #001's behaviours and stated some interventions they used with the resident.

RPN #130 described how the resident would become upset.

As per the home's "Internal Responsive Behaviour Protocol for Creedan Valley Care Community", for a new behaviour seen or triggered on RAI-MDS, the staff were to open a Responsive Behaviour Assessment in PCC, complete a DOS/ABC charting and analyze the information after one week to identify triggers. The P.I.E.C.E.S. assessment was to be used.

The home's policy entitled, Responsive Behaviours- Management, Policy #: VII-F-10.20, revised November 2018, instructed the Registered Staff to complete an electronic Responsive Behavioural Referral to the internal BSO Lead. The Interprofessional Care Team were to work together to "identify possible triggers for responsive behaviour based on preliminary evidence based assessments".

Paper copies of the P.I.E.C.E.S. Assessment Worksheets, located in the Behavioural Support Ontario (BSO) binder, were available for the registered staff to complete.

On an identified date, Digital Prescriber's orders stated that the doctor ordered Dementia Observation System (DOS) charting for seven days for aggressive behaviour. The DOS charting was not completed on each day of the monitoring.

RPN #130 stated that they had not been provided the DOS for review, PIECES assessments were not completed by the registered staff and the resident had not been referred to the external Behavioural Support System team.

ADOC #103 confirmed that the home did not complete an electronic Responsive Behavioural Referral or P.I.E.C.E.S. assessment of the resident to reassess the resident, identify interventions and assess the resident's response to interventions.

4. Two progress notes on two identified dates, stated resident #004 demonstrated a new responsive behaviour.

As per the home's "Internal Responsive Behaviour Protocol for Creedan Valley Care Community", for a new behaviour, the staff were to open a Responsive Behaviour Assessment in PCC, complete a DOS/ABC charting and analyze the information after one week to identify triggers. The PIECES assessment was to be used.

**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

The home's policy entitled, Responsive Behaviours- Management, Policy #: VII-F-10.20, revised November, 2018, instructed the Registered Staff to complete an electronic Responsive Behavioural Referral to the internal BSO Lead. The Interprofessional Care Team were to work together to "identify possible triggers for responsive behaviour based on preliminary evidence based assessments".

A treatment was ordered by the physician when needed for responsive behaviours.

DOS charting, a BSO electronic referral, and a PIECES assessment were not completed and therefore there were no triggers identified.

RPN #130 stated that they had not received a BSO referral and had not completed a DOS for resident #004's responsive behaviours.

The licensee failed to ensure that the actions were taken to meet the needs of resident's #030, #023, #001, #004 with responsive behaviours that included: reassessments, interventions, and documentation of the resident's responses to the interventions.

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it related to six of six residents reviewed. The home had a level 5 compliance history as this is a re-issued compliance order to the same section of O.Reg 79/10 that included: compliance order (CO) #002 issued August 28, 2018, with a compliance due date of September 7, 2018 (2018_742527_0013). (539)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 21, 2019

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:** 016

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

**Order / Ordre :**

**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

The licensee must be compliant with s. 87(2)(d) of O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that lingering offensive odours detected from the mattresses in the identified rooms are addressed.

b) Ensure that lingering offensive odours detected in the hallways outside the identified rooms, in the identified washrooms, and in the identified rooms are addressed.

c) Ensure that there are procedures developed and implemented for addressing incidents of lingering offensive odours throughout the home and that staff are aware of their roles and responsibilities.

**Grounds / Motifs :**

1. a) On identified dates, there were lingering offensive odours detected from the mattresses in three identified rooms.

PSW 119 stated that housekeeping staff were responsible for cleaning mattresses. However, PSWs #113 and #127 stated that they were responsible for cleaning mattresses for the residents on a weekly or as needed basis, however, there was no place for them to document that they had cleaned the mattress. They were unsure of the products and procedures that were in place to address any lingering odours coming from the mattress. They said no clear directions were given to them.

The DDS confirmed that there were lingering offensive odours detected from these mattresses. They stated that PSW staff were responsible for cleaning the mattresses and should have been using Clorox urine remover to get rid of offensive odours. They acknowledged that PSWs were not aware of this process and did not have access to Clorox urine remover.

b) During this inspection, lingering offensive odours were detected in identified resident living areas.

Housekeeping staff #137 and #144 stated that they used citrus spray and Clorox urine remover to address incidents of lingering offensive odours. They said that both these techniques were ineffective for addressing incidents of lingering offensive odours as some of these odours were part of the home's walls and flooring.

DDS #143 agreed that there were lingering offensive odours present in these specified areas and rooms. They added that this had been an ongoing concern for them as some of the urine had seeped into the flooring. They acknowledged that procedures were not implemented for addressing incidents of lingering offensive odours in these rooms.

The licensee has failed to ensure that procedures were developed and implemented for addressing incidents of lingering offensive odours. [s. 87. (2) (d)]

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it was widespread in the home. The home has a level 2 compliance history as there were previous non-compliances, none of which were to the same section/ subsection being cited. (696)

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 :** Aug 30, 2019

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:** 017

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,

(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum;

(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment;

(c) heating, ventilation and air conditioning systems are cleaned and in good state of repair and inspected at least every six months by a certified individual, and that documentation is kept of the inspection;

(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks;

(e) gas or electric fireplaces and heat generating equipment other than the heating system referred to in clause (c) are inspected by a qualified individual at least annually, and that documentation is kept of the inspection;

(f) hot water boilers and hot water holding tanks are serviced at least annually, and that documentation is kept of the service;

(g) the temperature of the water serving all bathtubs, showers, and hand basins used by residents does not exceed 49 degrees Celsius, and is controlled by a device, inaccessible to residents, that regulates the temperature;

(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius;

(i) the temperature of the hot water serving all bathtubs and showers used by residents is maintained at a temperature of at least 40 degrees Celsius;

(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and

(k) if the home is not using a computerized system to monitor the water temperature, the water temperature is monitored once per shift in random locations where residents have access to hot water. O. Reg. 79/10, s. 90 (2).

**Order / Ordre :**

**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

The licensee must be compliant with s. 90(2) of O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that procedures are developed and implemented to ensure that the heating, ventilation and air conditioning systems are cleaned, in a good state of repair, and inspected at least every six months by a certified individual, and that documentation is kept of the inspection.

b) Ensure that procedures are developed and implemented to ensure that the gas, electric fireplaces and heat generating equipment are inspected by a qualified individual at least annually, and that documentation is kept of the inspection.

c) Ensure that procedures are developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks.

d) Ensure that an auditing process is developed and fully implemented to ensure that deficiencies of plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are identified. This auditing process must be documented including the names of the people conducting the audit, the rooms that have been audited, the results of the audit and what actions were taken with regards to the audit results where deficiencies are identified.

**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

1. The licensee has failed to ensure that procedures were developed and implemented to ensure that the heating, ventilation and air conditioning systems were cleaned, in good state of repair, and inspected at least every six months by a certified individual, and that documentation was kept of the inspection

On identified dates, it was noted that the ceiling vents in the shower room, tub room, and hallways had copious amount of dust on them. Also, the ceiling vent in the identified hallway, was coming off from the left side as it was not fixed into the ceiling properly. It had rust on it and required painting.

The home's policy "Preventative Maintenance Task Schedule" last revised in November 2017, directed maintenance staff to perform routine monthly checks on HVAC and exhaust fan units and to change HVAC air filters on quarterly basis. HVAC, exhaust fans, and air conditioning units were to be inspected by a contracted service provider on a semi-annual basis and inspection report was to be documented.

A document titled "Risk management schedule form department: Maintenance" was found in the home's maintenance binder for 2018. It included all the tasks that were scheduled to be completed by maintenance services and their frequency. The sections for HVAC filter changes and equipment inspections were not checked off as being completed for the year of 2018.

During an interview with DDS #143, they were unable to provide documentation of the inspection report for the heating, ventilation, and air conditioning system. They acknowledged that the heating, ventilation and air conditioning systems in the home were not cleaned regularly and inspected every six months by a certified individual.

The licensee has failed to ensure that procedures were implemented to ensure that the heating, ventilation and air conditioning systems were cleaned, in good state of repair, and inspected at least every six months by a certified individual, and that documentation is kept of the inspection [s. 90. (2) (c)] (696)

## 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

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained and kept free of corrosion and cracks.

During this inspection, different room observations were made and the following areas of concerns were identified:

-The lid of the toilet tank in an identified room was not properly fitted as it was approximately 6 inches longer than the tank itself and was differently shaped. The lid extended beyond both ends of the tank.
-There was no lid present on the toilet tank in an identified room.
-The lids of the toilet tanks in two identified rooms did not fit properly.
-The base of the toilets in six identified rooms were black and dirty with no caulking present.

Maintenance care records in the home indicated that requests had been sent by staff regarding the toilet tank lids in two identified rooms.

DDS #143 stated that they were aware that some of the toilets in the home required caulking. They acknowledged that the toilets in the specified rooms were not maintained and should have been fixed immediately. They agreed that lids of the toilet tanks should have never been missing and should be well fitted.

The licensee has failed to ensure that procedures implemented to ensure that the toilets in the home were maintained and kept free of corrosion and cracks. [s. 90. (2) (d)]
(696)

**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

3. The licensee failed to ensure that procedures were developed and implemented to ensure that the gas, electric fireplaces and heat generating equipment (other than the home's HVAC system) were inspected by a qualified individual at least annually, and that documentation was kept of the inspection.

On two identified dates, it was observed that the cover of a baseboard heater in the main dining room was coming off, exposing the heating element underneath.

Environmental Service Manger #145 (ESM) from another Sienna care community, observed the broken cover of the baseboard heater and stated that it was a safety risk for the residents as the heating element was exposed.

The DDS #143, the interim lead for home's maintenance services, said that most of the home had electric baseboard heating except for a unit in the back dining room. They were unable to provide any documentation to show that home's heat generating equipment was inspected by a qualified individual on an annual basis. They were unsure of when the last inspection took place. They acknowledged that the home's heat generating equipment was not inspected annually by a qualified individual. [s. 90. (2) (e)]

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it was widespread in the home. The home has a level 2 compliance history as there were previous non-compliances, none of which were to the same section/ subsection being cited (696)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Aug 30, 2019

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:** 018

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

**Pursuant to / Aux termes de :**

O.Reg 79/10, s. 212. (1) Every licensee of a long-term care home shall ensure that the home's Administrator works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 64 beds or fewer, at least 16 hours per week.
2. In a home with a licensed bed capacity of more than 64 but fewer than 97 beds, at least 24 hours per week.
3. In a home with a licensed bed capacity of 97 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 212 (1).

**Order / Ordre :**

The licensee must be compliant with s. 212. (1) of O.Reg 79/10.

Specifically, the licensee must:

a) Ensure that the home's Administrator works regularly in that position on site at the home for at least 24 hours per week.

## 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. At the start of this inspection, Executive Director #100 shared that this was their second day at the home. They shared that they were also the current Executive Director at Midland Gardens and since their position at that home had not been filled they would be spending two days a week as Executive Director at Creedan Valley Care Community and Director of Care #101 would be covering as the Executive Director one day a week.

During this inspection, Executive Director #100 was observed to be in the home on identified dates.

During an interview with the Director of Care #101 they said that Executive Director #100 was at the home two days a week and in their absence the staff knew that they were to come to them if needed.

The licensee failed to ensure that the home's Administrator worked regularly in that position on site for at least 24 hours per week. [s. 212. (1)]

The severity of this issue was determined to be a level 2 as there was minimal harm or risk to the residents. The scope of the issue was a level 3 as it related to all residents in the home. The home has a level 2 compliance history as there were previous non-compliances, none of which were to the same section/ subsection being cited (155)

**This order must be complied with by /**
**Vous devez vous conformer à cet ordre d'ici le :** Jun 03, 2019

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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

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## 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.

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## Ordre(s) de l'inspecteur

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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

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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

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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  27th  day of January, 2020 (A4)**

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

**Name of Inspector /**
**Nom de l’inspecteur :**

Amended by SHARON PERRY (155) - (A4)

Ontario

**Ministry of Long-Term Care**

**Ministère des Soins de longue durée**

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**Service Area Office / Bureau régional de services :** Central West Service Area Office