Ontario

Ministry of Long-Term Care

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

Ministère des Soins de longue durée

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
Nov 04, 2021	2021_678590_0013 (A2)	002745-20, 012614-20, 017184-20, 025859-20, 003934-21, 007262-21, 007475-21	Complaint

Licensee/Titulaire de permis

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

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

Weston Terrace Care Community
2005 Lawrence Avenue West Toronto ON M9N 3V4

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

Amended by SLAVICA VUCKO (210) - (A2)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): May 31, and June 1 - 4 and 7 - 9, 2021.

The following intakes were completed in this complaint inspection:

Log #002745-20 and #017184-20 were related to resident care concerns;

Log #012614-20 was related to housekeeping and maintenance concerns, emergency supplies and cooling requirements;

Log #025859-20 was related to medication administration, infection prevention and control and nutrition and hydration;

Log #003934-21, #007262-21 and #007475-21 were related to prevention of abuse and neglect.

During the course of the inspection, the inspector(s) spoke with Director of Care, an Associate Director Of Care, a Physician, the Director of Environmental Services, the Housekeeping and Laundry Supervisor, the BSO Lead – Social Service Worker, a Registered Dietitian, three Registered Nurses, eight Registered Practical Nurses, seven Personal Support Workers, three Housekeepers, one Language Interpreter, one Resident and five family members.

During the course of the inspection, the inspector(s) observed the general cleanliness and maintenance of the common areas and resident home areas, infection prevention and control practices, dining services, the provision of resident care, recorded video evidence and reviewed residents' records, Infoline reports, policies or written procedures relevant to inspection topics, the homes complaint binder, email correspondence, quotes and invoices for maintenance repairs, Cooling Area Temperature Log Forms, Air Temperature Log Forms - Maintenance and a Quality Improvement Action Plan and internal investigation notes.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Dignity, Choice and Privacy
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

9 WN(s)
3 VPC(s)
5 CO(s)
0 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 maintained in a safe condition and in a good state of repair.

A complaint was received about the general condition of the home and upon an initial tour of the home on May 31, 2021, and subsequent observations on June 2, 3 and 8, 2021, the following was observed:

In general, throughout the home on each unit, there was wallpaper on the lower half of the walls. The wallpaper was peeling and gouged and some spots had been repaired or puttied in areas such as the lounge and activity areas, the hallways, public washrooms, resident rooms and their washrooms and tub rooms. Several hand sanitizer pumps were missing the catchers and sanitizer had dripped and dried stains down the walls to the floor. There were multiple handrails that were missing pieces and corners. Further observations throughout the inspection, revealed more specific areas:

The second floor: There was an area of putty on the wall outside room 204. Room 206 there were scratches on the door at the base and scratches along the base of the wall. Inspector also observed large gouges along wall to left of doorway. The wallpaper on the bottom half of the wall was peeling outside of room 207. The public residents washroom had areas of putty on the walls with attention to the sink area. The handrail outside the dining room was broken. The baseboard outside the electrical room was missing a piece. The walls in the tub room were severely scraped and gouged. There were missing heater covers.

The third floor: In room 352, the closet was observed to have the handle broken. The walls had gouges and some areas had been patched. There were holes in the wall where drywall plugs were. The residents' washroom had repairs patched all around the baseboards and under the sink, and the countertop was chipped and stained. Paint was chipped off the door jamb in the washroom and the washroom door had gouges along the base. In the lounge area there was a missing piece from a heater cover.

The fourth floor: The handrails outside room 406 and 413 as well as outside the staff room and multipurpose room were broken. Room 452 was missing a large piece of baseboard and the washroom was completely missing baseboards. The picture frame holding a residents’ picture from room 424 was broken. The residents washroom wall was damaged near the taps with gouges and chipped paint from the wall above the sink.

Review of the homes complaint binder from June 2020 to May 2021, revealed a

complaint had been lodged in November 2020 by a resident residing in the home that the wallpaper was falling off the wall in their room. The resident's room was repainted as a result.

The inspector and Director of Environmental Services #125 toured the second floor together. The Director acknowledged the areas observed on the second floor and throughout the building, needed work and that they were attempting to address all these issues. They were able to provide invoices for work recently completed related to flooring in the kitchen and tub rooms, plumbing and exhaust work, baseboard installation, handrails in some sections and quotes for planned work related to the wall, baseboard coverings and handrailings and stated that work still continued.

The licensee has failed to ensure that the handrails and heater covers were maintained in a safe condition and that the walls, baseboards and sanitizer dispensers were kept in a good state of repair.

Sources: Observations of resident home areas and staff utilized areas on the second, third and fourth floors; LTCH's complaint form; and interviews with Director of Environmental Services #125 and other staff members. [s. 15. (2) (c)]

Additional Required Actions:

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

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

WN #2: 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 #009 was protected from abuse by PSW’s #118 and #119.

For the purposes of the definition of “abuse” in subsection 2 (1) of the Act, “physical abuse” means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain,

An incident of abuse was reported to the home that had been captured on video from a camera in resident #009’s bedroom space. The incident had not been discovered until the video footage was reviewed by family at a later date. The video clip was three minutes and five seconds long and showed Personal Support Worker (PSW) #118 and #119 providing AM care to resident #009. The video clip's audio indicated that both PSW #118 and #119 were not verbally engaging the resident and speaking a language other than the resident’s identified language. PSW #118 and #119 were seen standing on either side of the bed and pulled resident #009 abruptly from a laying position to a sitting position by the residents’ arms and gave no verbal cueing. Resident #009 moaned during the abrupt action and had facial grimacing. PSW #118 and #119 did not acknowledge resident #009 when they called out and moaned and both staff released their hold from resident #009 allowing the resident to abruptly fall back into bed without support. Resident #009 continued to moan without acknowledgement. During an interview with resident #009 through a third-party language interpreter resident #009 indicated they were afraid of staff in the home.

Not protecting resident #009 from physical abuse from PSW #118 and #119 resulted in resident #009 experiencing physical harm and fear.

Sources: Resident's clinical record review, video clip and resident interview. [s. 19. (1)]

Additional Required Actions:

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

WN #3: 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,
(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).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained.

A complaint was received about the condition of the home in general and upon an initial tour of the home on May 31, 2021, and subsequent observations on June 2, 3 and 8, 2021, the following was observed:

- The sink in the public resident washroom located on unit 2A was missing the hot water tap and the hot water could not be turned on. The wall above the sink had paint chips on it and underneath the sink the wall was covered in putty that appeared to be cracking.
- The sink in the staff washroom was cracked around the sink and had putty underneath the sink.
- The sink in the public resident washroom located on 4A was leaking a constant stream of water. Both the hot and cold water taps were pushed into the wall where

they could not be pushed farther and had damaged the wall by chipping the paint and leaving small gouges. Underneath the sink the wall was covered in putty which appeared to be cracked.
- The utility sink on unit 2A was reported by Housekeeper #127 to be broken and couldn't be used, it was plugged with something. The housekeeper shared that the sink had been reported to the maintenance staff many times.
- The bathroom sink in resident room 352 had repairs patched under the sink. The taps were corroded and the hot water handle was positioned the wrong way, the drain was also corroded. The counter top had chips out of it and was stained.

In an interview with Director of Environmental Services #125 they shared that they had not been made aware of any of the malfunctioning sinks and would have them looked into and fixed as soon as possible. They shared that staff were educated to report any maintenance issues to the maintenance team through an online system that all the staff have access to, and can report any issues they see.

In an interview with Housekeepers #101, #124, #127 and PSWs #106 and #107, they all shared that they would report any broken items that needed attention from maintenance, to the registered staff and they'd submit an online form to maintenance.

In an interview with Registered Nurse (RN) #122, #123 and Registered Practical Nurse (RPN) #105, they shared that they report things to maintenance through an online system and if it's something emergent they will call the maintenance staff and tell them verbally.

Sources: Observations of resident home areas and staff utilized areas on the second, third and fourth floors; interviews with Director of Environmental Services #125 and other staff members. [s. 90. (2) (d)]

Additional Required Actions:

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

WN #4: 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,
(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; O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that procedures were implemented for the cleaning of the home, including, resident bedrooms and common areas, contact surfaces and wall surfaces.

A complaint was received about the condition of the home in general and upon an

initial tour of the home on May 31, 2021, and subsequent observations on June 2, 3 and 8, 2021, the following was observed:

The second floor: In the entrance to unit 2A there were stains on the walls below the windows to the lounge and on the lounge walls in some areas. The wall in the residents public bathroom in 2A appeared to be dirty in some areas below knee height. In the hallways outside rooms 211, 229 and 244 there were multiple stains on the wall below the handrails. There were several hand sanitizer pumps that had missing or broken catchers, letting the sanitizer from the pumps to drip down the walls at hand sanitizer stations throughout the building.

The third floor: The 3A dining room had a red fluid spill that had dried onto the radiator.

The fourth floor: There were stains on the walls below handrails throughout the hallways. The wall outside room 446 was visibly soiled.

The homes' policy titled "Wall Washing – Housekeeping", policy number: XII-F-10.00 and current revision date of March 2019, directed that wall washing will be done an on annual basis to maintain the surfaces and remove soil and that spot cleaning of walls is done on a daily basis during regular cleaning routines.

In an interview with Director of Environmental Services #125 and the Housekeeping and Laundry Supervisor #126 they shared that the walls were cleaned on an annual basis by the housekeeping staff and spots should be cleaned as needed in between as per the homes policy. During observation of the above mentioned areas with the Inspector, the Director acknowledged the appearance of some of the walls looking dirty and ensured that they would follow up with the Housekeeping staff for the designated areas.

Sources: Observations of resident home areas and staff utilized areas on the second, third and fourth floors; and interviews with Director of Environmental Services #125 and other staff members. [s. 87. (2) (a)]

2. The licensee has failed to ensure that procedures were implemented for the cleaning and disinfection of fall mats.

A complaint was received regarding the cleanliness of residents' rooms and their equipment. Upon the Inspectors observations of the identified resident's room a

soiled fall mat was observed. Three more fall mats were observed by Inspectors and two were observed to appear dirty, located in rooms 309 and 352.

The homes policy titled "Equipment Cleaning – Resident Care & Medical" policy number IX-G-20.90, current revision in June 2020, directed that equipment used for resident care and medical uses will be kept clean, and all equipment with shared use will be cleaned and disinfected between uses.

In an interview with Director of Environmental Services #125 they shared that there was a process in place for the cleaning of the fall mats and would follow up with the housekeeping staff for the designated area.

Sources: Observations of resident rooms; and interview with Director of Environmental Services #125 and other staff members. [s. 87. (2) (b)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 21. Air temperature

Specifically failed to comply with the following:

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor. O. Reg. 79/10, s. 21 (2).

s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

s. 21. (3) The temperature required to be measured under subsection (2) shall be documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night. O. Reg. 79/10, s. 21 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home and in one resident common area on every floor of the home.

Review of the May 2021 'Air Temperature Log Form – Maintenance, records that were provided, showed the following:

- The second floor contains units 2A and 2B: On both units air temperature recordings in common areas and resident rooms were missing on May 15 and 23, 2021, in the afternoon, and were also missing the evening shift on May 15, 16, 22, 23 and 29 – 31, 2021.

- The third floor contains units 3A and 3B: On both units air temperature

recordings in common areas and resident rooms were missing on May 15 and 23, 2021, in the afternoon, and were also missing the evening shift on May 15, 16, 22, 23 and 29 – 31, 2021.

- The fourth floor contains units 4A and 4B: On 4A air temperature recordings in common areas and resident rooms were missing on May 15 and 23, 2021, in the afternoon, and were also missing the evening shift on May 15, 16, 22, 23 and 29 – 31, 2021. On 4B air temperature recordings in common areas and resident rooms were missing on May 14, 15, 23, 2021, in the afternoon, and were also missing the evening shift on May 15, 16, 22, 23, 25 and 29 – 31, 2021.

In an interview with Director of Environmental Services #125, they observed the above missing documentation and acknowledged that there were some missing entries. They shared that the maintenance staff does the air temperature checks when they are in the building, but when they were not available they were not getting done at all in any of the identified areas.

Sources: LTCH's 'Air Temperature Log Form– Maintenance' records; and interview with Director of Environmental Services #125. [s. 21. (2) 1.]

2. The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area, if there were any in the home.

The home has 21 official cooling areas. The home has a total of seven units and each unit has three cooling areas, which are considered to be the Television room, the Activity room and the Dining room.

Review of the May 2021, 'Cooling Area Temperature Log Form' records that were provided, showed the following:

- The first floor contains unit 1A: Temperature recordings of the identified three cooling areas on the unit were not taken on May 16 and 22, 29 - 31 in the evening and on May 23, 2021, temperatures were not taken during the afternoon or in the evening.

- The second floor contains unit 2A and 2B: Temperature recordings of the combined six cooling areas on both units were not taken on May 16 and 22, 29 - 31 in the evening and on May 23, 2021, temperatures were not taken during the

afternoon or in evening.

- The third floor contains units 3A and 3B: On 3A temperature recordings of the identified three cooling areas were not taken on May 16 and 22 and 28 - 31 in the evening and on May 23, 2021 temperatures were not taken during the afternoon or in the evening. On 3B temperatures were not taken during the evening on May 16 and 22 and 29 – 31, and on May 23, 2021, temperatures were not taken during the afternoon or in the evening.

- The fourth floor contains units 4A and 4B: On both units, temperature recordings of the combined six cooling areas were not taken on May 16, 22 and 29 – 31 in the evening and on May 23, 2021, temperatures were not taken during the afternoon or in the evening.

In an interview with Director of Environmental Services #125, they observed the above missing documentation and acknowledged that there were some missing entries. They shared that the maintenance staff does the air temperature checks when they were in the building, but when they were not available they were not getting done at all in any of the identified areas.

Sources: LTCH's 'Cooling Area Temperature Log Form'; and interview with Director of Environmental Services #125. [s. 21. (2) 3.]

3. The licensee has failed to ensure that the temperatures required to be measured under subsection (2) were documented at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

Review of the records titled 'Cooling Area Temperature Log Form' and 'Air Temperature Log Form – Maintenance' for May of 2021, revealed that there were several temperatures that had not been taken or documented during either the afternoon and/or evening.

In an interview with Director of Environmental Services #125 they shared that the air temperatures had not always been taken or documented correctly and that moving forward interventions would be in place to ensure they were.

Sources: LTCH's 'Cooling Area Temperature Log Form' and 'Air Temperature Log Form – Maintenance' records; and interview with Director of Environmental

Services #125. [s. 21. (3)]

Additional Required Actions:

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

WN #6: 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:
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. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #007 was properly cared for in a manner consistent with his or her needs.

During the inspection, resident #007 told Inspector #522 that their bed had been made and when they checked their bed their bottom sheet was wet.

Resident #007 stated staff often will make their bed without changing their bottom sheet when it is wet.

Inspector #522 observed resident #007’s bed to be made and checked the bottom sheet which was damp.

In an interview, PSW #111 stated bed linen should be changed on a resident’s shower day and if it was wet or dirty. PSW #111 acknowledged resident #007’s bottom sheet was wet and had changed the bed.

In an interview, PSW #108 stated they made resident #007's bed in the morning and did not recall the bed being wet. When asked by Inspector #522 if they had checked if the bed sheets were wet, PSW #108 stated sometimes people miss things.

In an interview, Director of Care (DOC) #101 stated resident #007's sheets should have been changed and they had followed up with staff.

Sources: Observations of resident #007's bed, interviews with resident #007, PSW #108, PSW #111 and DOC #101. [s. 3. (1) 4.]

2. During the inspection, Inspector #522 noted the call bell in resident #008's room 223 started ringing.

During this time, Inspector #522 observed staff taking residents to their rooms from the dining room.

At 1257 hours, 17 minutes after resident #008 had rang their call bell, PSW #109 came to resident #008's room to answer their call bell. Inspector #522 heard resident #008 state to PSW #109 that their meal was cold.

In an interview, PSW #109 stated resident #008 likes their meal hot and if they do not eat right away it gets cold. PSW #109 did not give a reason for a delay in answering the call bell.

In an interview, resident #008 stated they normally waited awhile for their call bell to be answered.

In an interview with DOC #101, they stated it was everyone's responsibility to answer a call bell and that 17 minutes was too long for resident #008 to wait for their call bell to be answered. The DOC stated staff should answer the call bell and if they were busy let the resident know they would be back.

Sources: Observations of MacDonald Pathway home area and interviews with resident #008, PSW #109 and DOC #101. [s. 3. (1) 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 resident #007 and #008 are properly cared for in a manner consistent with their needs, to be implemented voluntarily.

WN #7: 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. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for resident #009 provided clear direction on communication, to staff and others who provide direct care to the resident.

Resident #009 was identified as having a language barrier. The resident was unable to understand most English and cannot communicate in English. During staff interviews with DOC #101, Resident Assessment Instrument Minimum Data Set (RAI/MDS) Coordinator #123, RN #121 and PSW #122, all indicated different ways to communicate with the resident. When asked where that information would be found to reference, all indicated the care plan. On review of the resident’s plan of care there was no direction to staff on how to effectively communicate with resident #009.

Not ensuring clear direction for communication to resident #009 placed the resident at risk to not be able to express needs or concerns as required.

Sources: Resident care plan and staff interviews with DOC, RAI coordinator #123, RN #121 and PSW #122. [s. 6. (1) (c)]

2. The licensee has failed to ensure that resident #003's plan of care provide clear direction regarding their oral intake.

During the inspection, resident #003 was observed to have a device that provided nutrition attached to their wheelchair.

A review of resident #003's electronic care plan noted under "Eating" that the resident required assistance for intake and was allowed other interventions for quality of life.

Under the Nutritional Care Plan it noted resident #003 required assistance with their nutritional intake and outlined specific interventions.

In an interview, Registered Dietitian (RD) #129 stated resident #003 required assistance with intake and that they had updated resident #003's nutritional care plan and the nurse was to update the nursing care plan. RD #129 reviewed resident #003's plan of care with Inspector #522 and acknowledged that it indicated that the resident was allowed specific interventions, and they updated resident #003's care plan to reflect the resident's other interventions for quality of life.

Sources: Observations of resident #003, review of resident #003's clinical records, plan of care and dietitian assessment; interviews with PSW #106, RPN #102 and Registered Dietitian #129. [s. 6. (1) (c)]

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 resident #003 and #009's plans of care provide clear direction to the staff, to be implemented voluntarily.

WN #8: 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 has failed to ensure that resident #002 and #003 received a shower twice per week.

A) Review of the home's Point of Care (POC) Documentation Survey report noted three occasions in 2021, where resident #002 did not receive a shower. The documentation stated the activity did not occur however it was documented that the resident did not require an altered level of care nor did the resident object to any assistance.

There was no documentation that the shower was made up or the resident had refused the shower.

B) Review of the home's POC Documentation Survey report, noted once that resident #003 did not receive a shower. The documentation stated the activity did not occur however it was documented that the resident did not require an altered level of care nor did the resident object to any assistance.

There was no documentation that the shower was made up or the resident had refused the shower.

In an interview, PSW #128 stated if a resident refused a bath they would re-approach the resident and if they refused again they would be offered a bed bath. PSW #123 stated they would document in POC that the activity did not occur and then under daily care that an altered level of care was required and report it to the registered staff.

In an interview, RN #123 stated if a resident did not get a bath it would be documented in the home area's 24-hour book. If a resident refused a bath it would also be documented in the resident's progress notes.

RN #123 reviewed the home area's 24-hour book with Inspector #522 and noted there was no documentation regarding resident #002 or #003 missing or refusing their showers.

Sources: Review of resident #002 and #003's clinical records, POC Documentation Survey report and interviews with PSW #128, RN #123, RN #122 and DOC #101. [s. 33. (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 resident #002 and #003 receive a shower or bath of their choice twice a week, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that resident #002 was dressed in clean footwear.

During the inspection, resident #002 was observed in the TV lounge. Resident #002 was wearing slippers that were visibly stained and soiled with food.

Two days later after this initial observation, RN #123 observed resident #002 with Inspector #522 and acknowledged that resident #002's slippers had food stains all over them. RN #123 tried to rub off the food stains, but they were dried in. RN #123 wrote in the home area's 24-hour book for the slippers to be laundered.

RN #123 stated it was up to all staff to ensure resident #002's footwear was clean.

Sources: Observations of resident #002, review of resident #002's clinical records and interviews with PSW #106, RN #123 and DOC #101. [s. 40.]

Issued on this 4 th day of November, 2021 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SLAVICA VUCKO (210) - (A2)
Inspection No. / No de l'inspection :	2021_678590_0013 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	002745-20, 012614-20, 017184-20, 025859-20, 003934-21, 007262-21, 007475-21 (A2)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 04, 2021(A2)
Licensee / Titulaire de permis :	2063414 Ontario Limited as General Partner of 2063414 Investment LP 302 Town Centre Blvd., Suite 300, Markham, ON, L3R-0E8
LTC Home / Foyer de SLD :	Weston Terrace Care Community 2005 Lawrence Avenue West, Toronto, ON, M9N-3V4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	John Seebach

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre: 001 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 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 comply with s. 15. (2) of the LTCHA.

Specifically, the licensee must:

- Ensure that the handrails throughout the building are intact, with no missing pieces or sharp edges and maintained in a good state of repair.

- Ensure that the walls are repaired and in a good condition. The walls in the home must be free of gouges and scrapes. The repairs must include the covering of repaired areas and the finishing of the walls, whether it be paint or wallpaper.

- Ensure that the hand sanitizer pumps throughout the building are repaired or replaced to prevent the excess drip of sanitizer down the walls.

- Ensure that the baseboards and heater covers throughout the building are in a good and safe condition where present and are replaced where missing.

- Ensure that the picture frame holding the residents picture outside room 424, is repaired.

Grounds / Motifs :

1. 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 complaint was received about the general condition of the home and upon an initial tour of the home on May 31, 2021, and subsequent observations on June 2, 3 and 8, 2021, the following was observed:

In general, throughout the home on each unit, there was wallpaper on the lower half of the walls. The wallpaper was peeling and gouged and some spots had been repaired or puttied in areas such as the lounge and activity areas, the hallways, public washrooms, resident rooms and their washrooms and tub rooms. Several hand sanitizer pumps were missing the catchers and sanitizer had dripped and dried stains down the walls to the floor. There were multiple handrails that were missing pieces and corners. Further observations throughout the inspection, revealed more specific areas:

The second floor: There was an area of putty on the wall outside room 204. Room 206 there were scratches on the door at the base and scratches along the base of the wall. Inspector also observed large gouges along wall to left of doorway. The wallpaper on the bottom half of the wall was peeling outside of room 207. The public residents washroom had areas of putty on the walls with attention to the sink area. The handrail outside the dining room was broken. The baseboard outside the electrical room was missing a piece. The walls in the tub room were severely scraped and gouged. There were missing heater covers.

The third floor: In room 352, the closet was observed to have the handle broken. The walls had gouges and some areas had been patched. There were holes in the wall where drywall plugs were. The residents' washroom had repairs patched all around the baseboards and under the sink, and the countertop was chipped and stained. Paint was chipped off the door jamb in the washroom and the washroom door had gouges along the base. In the lounge area there was a missing piece from a heater cover.

The fourth floor: The handrails outside room 406 and 413 as well as outside the staff room and multipurpose room were broken. Room 452 was missing a large piece of baseboard and the washroom was completely missing baseboards. The picture

frame holding a residents' picture from room 424 was broken. The residents washroom wall was damaged near the taps with gouges and chipped paint from the wall above the sink.

Review of the homes complaint binder from June 2020 to May 2021, revealed a complaint had been lodged in November 2020 by a resident residing in the home that the wallpaper was falling off the wall in their room. The resident's room was repainted as a result.

The inspector and Director of Environmental Services #125 toured the second floor together. The Director acknowledged the areas observed on the second floor and throughout the building, needed work and that they were attempting to address all these issues. They were able to provide invoices for work recently completed related to flooring in the kitchen and tub rooms, plumbing and exhaust work, baseboard installation, handrails in some sections and quotes for planned work related to the wall, baseboard coverings and handrailings and stated that work still continued.

The licensee has failed to ensure that the handrails and heater covers were maintained in a safe condition and that the walls, baseboards and sanitizer dispensers were kept in a good state of repair.

Sources: Observations of resident home areas and staff utilized areas on the second, third and fourth floors; LTCH's complaint form; and interviews with Director of Environmental Services #125 and other staff members.

An order was made by taking the following factors into account:

Severity: There was minimal risk for harm to residents related to the condition of the home, furnishings and equipment.

Scope: The scope was widespread as the Inspector observed 6 of the 7 resident home areas and made the same observations on each area.

Compliance History: In the last 36 months, the licensee was found to be non-compliant with LTCHA s. 15. (2) and two Written Notifications (WNs) were issued to the home.

(590)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Jan 06, 2022(A2)

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. 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 comply with s. 19. (1) of the LTCHA.

Specifically, the licensee must:

- Identify why resident #009 does not feel safe in the home.

- Identify interventions which will allow resident #009 to feel safe in the home.

- Ensure that the staff caring for resident #009 are aware of and implement the interventions in the residents plan of care at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that resident #009 was protected from abuse by PSW's #118 and #119.

For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, subject to subsection (2), (a) the use of physical force by anyone other than a resident that causes physical injury or pain,

An incident of abuse was reported to the home that had been captured on video from a camera in resident #009's bedroom space. The incident had not been discovered until the video footage was reviewed by family at a later date. The video clip was three minutes and five seconds long and showed Personal Support Worker (PSW) #118 and #119 providing AM care to resident #009. The video clip's audio indicated that both PSW #118 and #119 were not verbally engaging the resident and speaking

a language other than the resident's identified language. PSW #118 and #119 were seen standing on either side of the bed and pulled resident #009 abruptly from a laying position to a sitting position by the residents' arms and gave no verbal cueing. Resident #009 moaned during the abrupt action and had facial grimacing. PSW #118 and #119 did not acknowledge resident #009 when they called out and moaned and both staff released their hold from resident #009 allowing the resident to abruptly fall back into bed without support. Resident #009 continued to moan without acknowledgement. During an interview with resident #009 through a third-party language interpreter resident #009 indicated they were afraid of staff in the home.

Not protecting resident #009 from physical abuse from PSW #118 and #119 resulted in resident #009 experiencing physical harm and fear.

Sources: Resident's clinical record review, video clip and resident interview.

An order was made by taking the following factors into account:

Severity: Resident #009 experienced actual harm, as they developed fear of the staff after the incident.

Scope: This was an isolated case as no other incidents of physical abuse were identified during this inspection.

Compliance History: In the last 36 months, the licensee was found to be non-compliane with LTCHA s. 15. (1) and two Voluntary Plan of Corrections (VPCs) were issued to the home.

(725)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 06, 2021

Order # / No d'ordre: 003

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 :

The licensee must comply with s. 90. (2) of O. Reg. 79/10.

Specifically, the licensee must:

- Ensure that every sink in the home has hot and cold water taps and that they do not leak.

- Ensure that the sinks are functioning at all times.

- Ensure that the immediate wall area around the sinks are repaired, free of cracks and are finished.

- Ensure that the sinks and their accessories are kept free of corrosion and cracks.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were implemented to ensure that the plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories were maintained.

A complaint was received about the condition of the home in general and upon an initial tour of the home on May 31, 2021, and subsequent observations on June 2, 3 and 8, 2021, the following was observed:

- The sink in the public resident washroom located on unit 2A was missing the hot water tap and the hot water could not be turned on. The wall above the sink had paint chips on it and underneath the sink the wall was covered in putty that appeared to be cracking.
- The sink in the staff washroom was cracked around the sink and had putty underneath the sink.
- The sink in the public resident washroom located on 4A was leaking a constant stream of water. Both the hot and cold water taps were pushed into the wall where they could not be pushed farther and had damaged the wall by chipping the paint and leaving small gouges. Underneath the sink the wall was covered in putty which appeared to be cracked.
- The utility sink on unit 2A was reported by Housekeeper #127 to be broken and couldn't be used, it was plugged with something. The housekeeper shared that the

sink had been reported to the maintenance staff many times.
- The bathroom sink in resident room 352 had repairs patched under the sink. The taps were corroded and the hot water handle was positioned the wrong way, the drain was also corroded. The counter top had chips out of it and was stained.

In an interview with Director of Environmental Services #125 they shared that they had not been made aware of any of the malfunctioning sinks and would have them looked into and fixed as soon as possible. They shared that staff were educated to report any maintenance issues to the maintenance team through an online system that all the staff have access to, and can report any issues they see.

In an interview with Housekeepers #101, #124, #127 and PSWs #106 and #107, they all shared that they would report any broken items that needed attention from maintenance, to the registered staff and they'd submit an online form to maintenance.

In an interview with Registered Nurse (RN) #122, #123 and Registered Practical Nurse (RPN) #105, they shared that they report things to maintenance through an online system and if it's something emergent they will call the maintenance staff and tell them verbally.

Sources: Observations of resident home areas and staff utilized areas on the second, third and fourth floors; interviews with Director of Environmental Services #125 and other staff members.

An order was made by taking the following factors into account:

Severity: There was minimal risk for harm related to the malfunctioning sinks. Each resident has a sink in their own room to use.

Scope: The scope of this non-compliance was identified as a pattern as three of the sinks that were observed, were sinks that residents used.

Compliance History: 54 Written Notifications (WNs) and 33 Voluntary Plans of Corrections (VPCs) were issued to the home related to different sections of the legislation in the past 36 months. (590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le :

Nov 05, 2021

Order # / No d'ordre: 004 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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 :

The licensee must comply with s. 87. (2) of O. Reg. 79/10.

Specifically, the licensee must:

- Ensure that the walls and surfaces throughout the building are kept clean and free of stains, spills and debris.

- Ensure that fall mats are kept clean and free of debris.

Grounds / Motifs :

1. The licensee has failed to ensure that procedures were implemented for the cleaning of the home, including, resident bedrooms and common areas, contact surfaces and wall surfaces.

A complaint was received about the condition of the home in general and upon an initial tour of the home on May 31, 2021, and subsequent observations on June 2, 3 and 8, 2021, the following was observed:

The second floor: In the entrance to unit 2A there were stains on the walls below the windows to the lounge and on the lounge walls in some areas. The wall in the residents public bathroom in 2A appeared to be dirty in some areas below knee height. In the hallways outside rooms 211, 229 and 244 there were multiple stains on the wall below the handrails. There were several hand sanitizer pumps that had missing or broken catchers, letting the sanitizer from the pumps to drip down the walls at hand sanitizer stations throughout the building.

The third floor: The 3A dining room had a red fluid spill that had dried onto the radiator.

The fourth floor: There were stains on the walls below handrails throughout the hallways. The wall outside room 446 was visibly soiled.

The homes' policy titled "Wall Washing – Housekeeping", policy number: XII-F-10.00 and current revision date of March 2019, directed that wall washing will be done an on annual basis to maintain the surfaces and remove soil and that spot cleaning of walls is done on a daily basis during regular cleaning routines.

In an interview with Director of Environmental Services #125 and the Housekeeping and Laundry Supervisor #126 they shared that the walls were cleaned on an annual basis by the housekeeping staff and spots should be cleaned as needed in between as per the homes policy. During observation of the above mentioned areas with the Inspector, the Director acknowledged the appearance of some of the walls looking dirty and ensured that they would follow up with the Housekeeping staff for the designated areas.

Sources: Observations of resident home areas and staff utilized areas on the

second, third and fourth floors; and interviews with Director of Environmental Services #125 and other staff members.
(590)

2. The licensee has failed to ensure that procedures were implemented for the cleaning and disinfection of fall mats.

A complaint was received regarding the cleanliness of residents' rooms and their equipment. Upon the Inspectors observations of the identified resident's room a soiled fall mat was observed. Three more fall mats were observed by Inspectors and two were observed to appear dirty, located in rooms 309 and 352.

The homes policy titled "Equipment Cleaning – Resident Care & Medical" policy number IX-G-20.90, current revision in June 2020, directed that equipment used for resident care and medical uses will be kept clean, and all equipment with shared use will be cleaned and disinfected between uses.

In an interview with Director of Environmental Services #125 they shared that there was a process in place for the cleaning of the fall mats and would follow up with the housekeeping staff for the designated area.

Sources: Observations of resident rooms; and interview with Director of Environmental Services #125 and other staff members.

An order was made by taking the following factors into account:

Severity: There was no harm to the residents related to the cleanliness of the walls and surfaces and fall mats.

Scope: This non-compliance was widespread as observations of the walls and surfaces were made on six of the seven resident home areas. Two of four fall mats observed appeared to be soiled or have debris on them.

Compliance History: 54 Written Notifications (WNs) and 33 Voluntary Plans of Corrections (VPCs) were issued to the home related to different sections of the legislation in the past 36 months.
(590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 22, 2021

Order # / No d'ordre: 005 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 21. (2) Every licensee of a long-term care home shall ensure that the temperature is measured and documented in writing, at a minimum in the following areas of the home:
1. At least two resident bedrooms in different parts of the home.
2. One resident common area on every floor of the home, which may include a lounge, dining area or corridor.
3. Every designated cooling area, if there are any in the home. O. Reg. 79/10, s. 21 (2).

Order / Ordre :

The licensee must comply with s. 21. (2) of O.Reg 79/10.

Specifically, the licensee must:

- Ensure that the air temperature is measured and documented in writing in at least two resident bedrooms in different parts of the home, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

- Ensure that the air temperature is measured and documented in writing in one resident common area on every floor of the home, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

- Ensure that the air temperature is measured and documented in writing in every designated cooling area, at least once every morning, once every afternoon between 12 p.m. and 5 p.m. and once every evening or night.

- Ensure that there is always a designated person responsible and available in the building, to complete the air temperature measurements and required documentation in the absence of the regularly designated staff members.

- Ensure that the designated staff members completing the air temperatures, know what to do when an abnormal air temperature recording is observed.

Grounds / Motifs :

1. The licensee has failed to ensure that the temperature was measured and documented in writing in at least two resident bedrooms in different parts of the home and in one resident common area on every floor of the home.

Review of the May 2021 'Air Temperature Log Form – Maintenance, records that were provided, showed the following:

- The second floor contains units 2A and 2B: On both units air temperature recordings in common areas and resident rooms were missing on May 15 and 23, 2021, in the afternoon, and were also missing the evening shift on May 15, 16, 22, 23 and 29 – 31, 2021.

- The third floor contains units 3A and 3B: On both units air temperature recordings in common areas and resident rooms were missing on May 15 and 23, 2021, in the afternoon, and were also missing the evening shift on May 15, 16, 22, 23 and 29 – 31, 2021.

- The fourth floor contains units 4A and 4B: On 4A air temperature recordings in common areas and resident rooms were missing on May 15 and 23, 2021, in the afternoon, and were also missing the evening shift on May 15, 16, 22, 23 and 29 – 31, 2021. On 4B air temperature recordings in common areas and resident rooms were missing on May 14, 15, 23, 2021, in the afternoon, and were also missing the evening shift on May 15, 16, 22, 23, 25 and 29 – 31, 2021.

In an interview with Director of Environmental Services #125, they observed the above missing documentation and acknowledged that there were some missing entries. They shared that the maintenance staff does the air temperature checks when they are in the building, but when they were not available they were not getting done at all in any of the identified areas.

Sources: LTCH's 'Air Temperature Log Form – Maintenance' records; and interview with Director of Environmental Services #125. (590)

2. The licensee has failed to ensure that the temperature was measured and documented in writing in every designated cooling area, if there were any in the home.

The home has 21 official cooling areas. The home has a total of seven units and

each unit has three cooling areas, which are considered to be the Television room, the Activity room and the Dining room.

Review of the May 2021, 'Cooling Area Temperature Log Form' records that were provided, showed the following:

- The first floor contains unit 1A: Temperature recordings of the identified three cooling areas on the unit were not taken on May 16 and 22, 29 - 31 in the evening and on May 23, 2021, temperatures were not taken during the afternoon or in the evening.

- The second floor contains unit 2A and 2B: Temperature recordings of the combined six cooling areas on both units were not taken on May 16 and 22, 29 - 31 in the evening and on May 23, 2021, temperatures were not taken during the afternoon or in evening.

- The third floor contains units 3A and 3B: On 3A temperature recordings of the identified three cooling areas were not taken on May 16 and 22 and 28 - 31 in the evening and on May 23, 2021 temperatures were not taken during the afternoon or in the evening. On 3B temperatures were not taken during the evening on May 16 and 22 and 29 – 31, and on May 23, 2021, temperatures were not taken during the afternoon or in the evening.

- The fourth floor contains units 4A and 4B: On both units, temperature recordings of the combined six cooling areas were not taken on May 16, 22 and 29 – 31 in the evening and on May 23, 2021, temperatures were not taken during the afternoon or in the evening.

In an interview with Director of Environmental Services #125, they observed the above missing documentation and acknowledged that there were some missing entries. They shared that the maintenance staff does the air temperature checks when they were in the building, but when they were not available they were not getting done at all in any of the identified areas.

Sources: LTCH's 'Cooling Area Temperature Log Form'; and interview with Director o Environmental Services #125.

An order was made by taking the following factors into account:

Severity: There was minimal risk for harm as the air temperatures that were completed, were being completed during the hottest times of the day when maintenance staff were present.

Scope: This non-compliance was widespread as temperatures were not being taken anywhere in the building when maintenance staff were not available.

Compliance History: 54 Written Notifications (WNs) and 33 Voluntary Plans of Corrections (VPCs) were issued to the home related to different sections of the legislation in the past 36 months. (590)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 21, 2021

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
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:

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
438 University Avenue, 8th Floor
Toronto, ON M7A 1N3
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère des Soins de longue durée
438, rue University, 8e étage
Toronto ON M7A 1N3
Télécopieur : 416-327-7603

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
438, rue University, 8e étage
Toronto ON M7A 1N3
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 4 th day of November, 2021 (A2)

Signature of Inspector / Signature de l'inspecteur :

Name of Inspector / Nom de l'inspecteur : Amended by SLAVICA VUCKO (210) - (A2)

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