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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Public Copy/Copie du rapport public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 26, 2020	2020_745690_0009	003299-20, 003300-20	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

Muskoka Shores Care Community
200 Kelly Drive GRAVENHURST ON P1P 1P3

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

TRACY MUCHMAKER (690)

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): June 1-4, 2020, June 9-12, and June 16-19, 2020.

The Following intakes were inspected upon during this Follow Up Inspection:

-One log, related to CO #001 from Inspection report #2020_746692_0004, regarding s. 19 (1) of the Long-Term Care Homes Act (LTCHA), specific to the home protecting residents from abuse and ensuring that residents were not neglected by the licensee or staff.
-One log, related to CO #001 from Inspection report #2020_746692_0005, regarding s. 20 (1) of the Long-Term Care Homes Act (LTCHA), specific to ensuring that the written policy to promote zero tolerance of abuse and neglect was complied with.

Complaint Inspection #2020_745690_0007 was conducted concurrently with this inspection.

Critical Incident System Inspection #2020_745690_0008 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), Nurse Managers (NM), Director of Resident Relations, Environmental Services Manager (ESM), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), and residents.

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

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

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

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 20. (1)	CO #001	2020_746692_0005	690

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. 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 residents were not neglected by staff.

Compliance order #001 was served to the licensee on February 21, 2020, from inspection report #2020_746692_0004, related to section 19 (1), of the Long-Term Care Home's Act (LTCHA) 2007, and had a compliance due date of April 3, 2020. The compliance order stated: The licensee must be compliant with s. 19 (1) of the Long Term Care Homes Act (LTCHA), 2007. Specifically, the licensee must ensure that residents were not neglected by staff.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "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”

During inspection #2020_746692_0004, the grounds to support the compliance order focused on staff response time to resident's activating their call bell. Inspector #690 reviewed the audits of the call bell system reports conducted by the home. Each report was generated when the call bell exceeded the long term care home's standard of 20 minutes. The Inspector identified numerous call bell system reports that indicated that the call bells were not responded to until after 20 minutes of being activated. The Inspector viewed documents titled “Alarm Average Response Time Report”, which identified the times the washroom call bell was activated by resident #001, and the length of time the call bell was activated for before being responded to. The reports indicated the following:

-On the first date- washroom call bell was activated and rang for 21 minutes before being turned off;
-On the second date-washroom call bell activated and rang for 27 minutes before being turned off;
-On the third date-washroom call bell activated and rang for 21 minutes before being turned off.

Inspector #692 reviewed resident #001's health care records, identifying that they had multiple co-morbitities. A review of the resident's care plan indicated that the resident was a high risk for falls, and required a specified level of assistance from staff for identified Activities of Daily Living (ADLs). [s. 19. (1)]

2. The Inspector viewed the Alarm Average Response Time Reports for resident #009. The reports identified the times the resident’s bed alarm, chair alarm, washroom, and room call bell was activated, and the length of time the call bell was activated for before

being responded to. The reports indicated the following:

-On the first date-bed alarm was activated and was alarming for 25 minutes and 27 seconds;
-On the second date-bed alarm was activated and was alarming for 20 minutes and 14 seconds before being turned off;
-On the third date-room call bell was activated and rang for 32 minutes and 39 seconds before being turned off;
-On the fourth date-washroom call bell was activated and rang for 29 minutes and 3 seconds before being turned off;
-On the fifth-bed alarm was activated and alarmed for 20 minutes and 8 seconds before being turned off;
-On the sixth date-chair alarm was activated and alarmed for 20 minutes and 2 seconds before being turned off;
-On the seventh date-bed alarm was activated and alarmed for 25 minutes and 54 seconds before being turned off;
-On the eighth date-bed alarm was activated and alarmed for 20 minutes and 16 seconds, additionally the bed alarm was activated on the same date and alarmed for 20 minutes and 6 seconds, before being turned off.

The Inspector reviewed health records for resident #009 and identified that the resident had multiple co-morbidities. A review of the care plan identified that the resident was at high risk of falling, and required a specified level of assistance from staff for identified ADLs. [s. 19. (1)]

3. The Inspector viewed the Alarm Average Response Time Reports for resident #011. The reports identified the times the resident’s bed alarm, and room call bell was activated, and the length of time the call bell was activated for before being responded to. The reports indicated the following:

-On the first date- room call bell was activated and rang for 56 minutes and 33 seconds, and the bed alarm was activated on the same date at and was ringing for 20 minutes and 9 seconds before being turned off;
-On the second date-room call bell was activated rang for 25 minutes and 5 seconds before being turned off;
-On the third date-bed alarm was activated at and was alarming for 34 minutes and 55 seconds before being turned off’;
-On the fourth date-room call bell was activated and rang for 23 minutes and 11 seconds

before being turned off;
-On the fifth date-room call bell was activated and rang for 22 minutes and 43 seconds before being turned off;
-On the sixth date-room call bell was activated and rang for 35 minutes and 40 seconds before being turned off;
-On the seventh date-room call bell was activated and rang for 21 minutes and 43 seconds before being turned off;

The Inspector reviewed health records for resident #011 and identified that the resident had specified medical diagnosis. A review of the care plan identified that the resident was at high risk of falling and had a bed alarm, and chair alarm in place. The care plan further identified that the resident required a specified level of assistance from staff for identified ADLs. [s. 19. (1)]

4. The Inspector viewed the Alarm Average Response Time Reports for an identified room, which was occupied by residents #013, and #014. The reports did not identify which resident activated the call bell. The reports identified the times the resident’s washroom, and room call bell were activated, and the length of time the call bell was activated for before being responded to. The reports indicated the following:

-On the first date-room call bell was activated and rang for 60 minutes and 54 seconds before being turned off;
-On the second date-room call bell was activated and rang for 60 minutes and 32 seconds before being turned off;
-On the third date-washroom call bell was activated and rang for 33 minutes and 32 seconds before being turned off.

The Inspector reviewed health records for resident #013 and identified that the resident had multiple co-morbidities. A review of the care plan identified that the resident was at high risk of falling, and had a bed and chair alarm in place, and required a specified level of assistance for identified ADLs.

The Inspector reviewed health records for resident #014 and identified that the resident had multiple co-morbidities. A review of the care plan identified that the resident required a specified level of assistance of staff for identified ADLs.

A review of the home’s policy titled, “Prevention of Abuse and Neglect of a Resident, #VII-G-10.00”, last updated April 2019, indicated that abuse and neglect were not

tolerated in any circumstance by anyone, and any deviation from this standard would not be tolerated.

A review of the call bell follow up reports indicated that numerous staff had received re-education on the call bell policy, resident’s rights and the expectation of answering the call bells. PSW #105, PSW #113, PSW #114, PSW #115, PSW #116, had all received disciplinary action as well for on-going concerns related to not responding to the call bells in a timely manner. RPN #119, and RPN #128, had received re-education and had been spoken to on the expectations of answering the call bells.

The Inspector reviewed disciplinary documents, for PSW #105, PSW #114, PSW #116, that indicated disciplinary action in response to not answering call bells, bed and chair alarms in a timely manner. The documents further indicated that the staff members actions and behaviours had been “negligent” and that the compromise of resident care was a continued concern. In addition, the inspector viewed a document for PSW #113, which indicated a further disciplinary in response to not answering call bells, bed and chair alarms in a timely manner. The document further indicated that the staff members actions and behaviours had been “negligent” and that the compromise of resident care was a continued concern.

In separate interviews with Personal Support Worker PSW #113, PSW #114, PSW #116, and PSW #121, they all indicated that when a resident activated their call bell, either in their room, the washroom or their bed and/or chair alarm, a message was sent to the PSWs pager alerting them to which room the call bell was activated in. The call bell was deactivated when staff responded to the call bell, turning it off at the point of activation. The PSWs further indicated that when a resident’s call bell, bed alarm or chair alarm was ringing, that it was the expectation that the bell or alarm was answered as soon as possible. The PSW’s indicated that when resident’s call bells are ringing for 20 minutes or more, it was unacceptable and that it could put the resident’s safety in jeopardy.

In separate interviews with Registered Practical Nurse (RPN) #103, RPN #119, RPN #125, and RPN #128, they indicated that when a resident activated their call bell, it would ring first to the PSW pagers, and if the call bell continued to ring for a period of nine minutes, then a message would be sent to the RPN pager. The RPNs further indicated that if a message was sent to the RPN pager, then it was the expectation that they respond to the call bell right away. The RPNs indicated that if a resident was waiting for more than 20 minutes, that was unacceptable and it could put the resident’s safety in jeopardy.

In separate interviews with Nurse Manager (NM) #118, they indicated that they would review a report each morning of the call bell response times for the past 24 hours, and that any call bell, or bed and chair alarms that were ringing for 20 minutes or longer would be indicated on the report. The NM further indicated that they would look to see which PSW was responsible for providing care to that resident at the time, and they would follow up with the respective staff members, by providing re-education. The NM also indicated that if they had to follow up with the same staff members again, they would progress to disciplinary action with the staff members. A review of the above mentioned alarm average response time reports, by the NM indicated that the length of time that staff were taking to respond to the call bells and bed alarms was not acceptable and could pose a risk to the residents.

In separate interviews with Assistant Directors of Care (ADOC) #126, and ADOC #127, they indicated that they would also review the daily reports of the call bell response times and would follow up with the staff that were responsible. Both ADOCs, indicated that the above mentioned call bell response times, were not acceptable, and could put the resident's safety at risk. They further indicated that they continue to follow up with staff, and have started following up with the RPN staff as well. ADOC #126 identified that there are some staff that they keep having to follow up with and have provided disciplinary action, included.

In an interview with the Director of Care (DOC), they indicated that the home had been auditing the call bell response times, and following up with staff for any reports that indicated that the call bells were ringing for more than 20 minutes before staff responded to them. The DOC indicated that although there had been improvement in the call bell response times, they continue to have call bells that ring for more than 20 minutes, which potentially jeopardizes the safety of the residents. [s. 19. (1)]

Additional Required Actions:

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

Issued on this 30th day of June, 2020

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

Original report signed by the inspector.

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2020_745690_0009
Log No. / No de registre :	003299-20, 003300-20
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Jun 26, 2020
Licensee / Titulaire de permis :	2063412 Ontario Limited as General Partner of 2063412 Investment LP 302 Town Centre Blvd., Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Muskoka Shores Care Community 200 Kelly Drive, GRAVENHURST, ON, P1P-1P3
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Angela Coutts

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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 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 # / No d'ordre : 001

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

Linked to Existing Order / Lien vers ordre existant: 2020_746692_0004, 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 Long Term Care Homes Act (LTCHA), 2007.

The licensee shall prepare, submit and implement a plan to ensure that residents are not neglected by staff, specific to staff responding to activated call bells. The plan must include, but is not limited, to the following:

- How the home will continue to audit the call bell system reports routinely, and follow up with any deficiencies;
- Maintain a detailed record of any deficiencies, including the date, time, call bell location, staff involved, what the deficiency was, what was done to correct the deficiency and the person that followed up on the deficiency.

Please submit the written plan for achieving compliance for, 2020_745690_0009 to Tracy Muchmaker, LTC Homes Inspector, MOHLTC, by email to SudburySAO.moh@ontario.ca by July 10, 2020.

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

Grounds / Motifs :

1. The licensee has failed to ensure that residents were not neglected by staff.

Compliance order #001 was served to the licensee on February 21, 2020, from inspection report #2020_746692_0004, related to section 19 (1), of the Long-Term Care Home's Act (LTCHA)2007, and had a compliance due date of April 3, 2020. The compliance order stated: The licensee must be compliant with s.

19 (1) of the Long Term Care Homes Act (LTCHA), 2007. Specifically, the licensee must ensure that residents were not neglected by staff.

Neglect is defined within the Ontario Regulations 79/10 of the Long-Term Care Homes Act (LTCHA) as "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"

During inspection #2020_746692_0004, the grounds to support the compliance order focused on staff response time to resident's activating their call bell. Inspector #690 reviewed the audits of the call bell system reports conducted by the home. Each report was generated when the call bell exceeded the long term care home's standard of 20 minutes. The Inspector identified numerous call bell system reports that indicated that the call bells were not responded to until after 20 minutes of being activated. The Inspector viewed documents titled "Alarm Average Response Time Report", which identified the times the washroom call bell was activated by resident #001, and the length of time the call bell was activated for before being responded to. The reports indicated the following:

-On the first date- washroom call bell was activated and rang for 21 minutes before being turned off;
-On the second date-washroom call bell activated and rang for 27 minutes before being turned off;
-On the third date-washroom call bell activated and rang for 21 minutes before being turned off.

Inspector #692 reviewed resident #001's health care records, identifying that they had multiple co-morbitities. A review of the resident's care plan indicated that the resident was a high risk for falls, and required a specified level of assistance from staff for identified Activities of Daily Living (ADLs). [s. 19. (1)] (690)

2. The Inspector viewed the Alarm Average Response Time Reports for resident #009. The reports identified the times the resident's bed alarm, chair alarm, washroom, and room call bell was activated, and the length of time the call bell was activated for before being responded to. The reports indicated the following:

-On the first date-bed alarm was activated and was alarming for 25 minutes and 27 seconds;
-On the second date-bed alarm was activated and was alarming for 20 minutes and 14 seconds before being turned off;
-On the third date-room call bell was activated and rang for 32 minutes and 39 seconds before being turned off;
-On the fourth date-washroom call bell was activated and rang for 29 minutes and 3 seconds before being turned off;
-On the fifth-bed alarm was activated and alarmed for 20 minutes and 8 seconds before being turned off;
-On the sixth date-chair alarm was activated and alarmed for 20 minutes and 2 seconds before being turned off;
-On the seventh date-bed alarm was activated and alarmed for 25 minutes and 54 seconds before being turned off;
-On the eighth date-bed alarm was activated and alarmed for 20 minutes and 16 seconds, additionally the bed alarm was activated on the same date and alarmed for 20 minutes and 6 seconds, before being turned off.

The Inspector reviewed health records for resident #009 and identified that the resident had multiple co-morbidities. A review of the care plan identified that the resident was at high risk of falling, and required a specified level of assistance from staff for identified ADLs. [s. 19. (1)]

(690)

3. The Inspector viewed the Alarm Average Response Time Reports for resident #011. The reports identified the times the resident's bed alarm, and room call bell was activated, and the length of time the call bell was activated for before being responded to. The reports indicated the following:

-On the first date- room call bell was activated and rang for 56 minutes and 33 seconds, and the bed alarm was activated on the same date at and was ringing for 20 minutes and 9 seconds before being turned off;
-On the second date-room call bell was activated rang for 25 minutes and 5 seconds before being turned off;
-On the third date-bed alarm was activated at and was alarming for 34 minutes

and 55 seconds before being turned off';
-On the fourth date-room call bell was activated and rang for 23 minutes and 11 seconds before being turned off;
-On the fifth date-room call bell was activated and rang for 22 minutes and 43 seconds before being turned off;
-On the sixth date-room call bell was activated and rang for 35 minutes and 40 seconds before being turned off;
-On the seventh date-room call bell was activated and rang for 21 minutes and 43 seconds before being turned off;

The Inspector reviewed health records for resident #011 and identified that the resident had specified medical diagnosis. A review of the care plan identified that the resident was at high risk of falling and had a bed alarm, and chair alarm in place. The care plan further identified that the resident required a specified level of assistance from staff for identified ADLs. [s. 19. (1)]

(690)

4. The Inspector viewed the Alarm Average Response Time Reports for an identified room, which was occupied by residents #013, and #014. The reports did not identify which resident activated the call bell. The reports identified the times the resident's washroom, and room call bell were activated, and the length of time the call bell was activated for before being responded to. The reports indicated the following:

-On the first date-room call bell was activated and rang for 60 minutes and 54 seconds before being turned off;
-On the second date-room call bell was activated and rang for 60 minutes and 32 seconds before being turned off;
-On the third date-washroom call bell was activated and rang for 33 minutes and 32 seconds before being turned off.

The Inspector reviewed health records for resident #013 and identified that the resident had multiple co-morbidities. A review of the care plan identified that the resident was at high risk of falling, and had a bed and chair alarm in place, and required a specified level of assistance for identified ADLs.

The Inspector reviewed health records for resident #014 and identified that the resident had multiple co-morbidities. A review of the care plan identified that the resident required a specified level of assistance of staff for identified ADLs.

A review of the home's policy titled, "Prevention of Abuse and Neglect of a Resident, #VII-G-10.00", last updated April 2019, indicated that abuse and neglect were not tolerated in any circumstance by anyone, and any deviation from this standard would not be tolerated.

A review of the call bell follow up reports indicated that numerous staff had received re-education on the call bell policy, resident's rights and the expectation of answering the call bells. PSW #105, PSW #113, PSW #114, PSW #115, PSW #116, had all received disciplinary action as well for on-going concerns related to not responding to the call bells in a timely manner. RPN #119, and RPN #128, had received re-education and had been spoken to on the expectations of answering the call bells.

The Inspector reviewed disciplinary documents, for PSW #105, PSW #114, PSW #116, that indicated disciplinary action in response to not answering call bells, bed and chair alarms in a timely manner. The documents further indicated that the staff members actions and behaviours had been "negligent" and that the compromise of resident care was a continued concern. In addition, the inspector viewed a document for PSW #113, which indicated a further disciplinary in response to not answering call bells, bed and chair alarms in a timely manner. The document further indicated that the staff members actions and behaviours had been "negligent" and that the compromise of resident care was a continued concern.

In separate interviews with Personal Support Worker PSW #113, PSW #114, PSW #116, and PSW #121, they all indicated that when a resident activated their call bell, either in their room, the washroom or their bed and/or chair alarm, a message was sent to the PSWs pager alerting them to which room the call bell was activated in. The call bell was deactivated when staff responded to the call bell, turning it off at the point of activation. The PSWs further indicated that when a resident's call bell, bed alarm or chair alarm was ringing, that it was the expectation that the bell or alarm was answered as soon as possible. The PSW's indicated that when resident's call bells are ringing for 20 minutes or

more, it was unacceptable and that it could put the resident's safety in jeopardy.

In separate interviews with Registered Practical Nurse (RPN) #103, RPN #119, RPN #125, and RPN #128, they indicated that when a resident activated their call bell, it would ring first to the PSW pagers, and if the call bell continued to ring for a period of nine minutes, then a message would be sent to the RPN pager. The RPNs further indicated that if a message was sent to the RPN pager, then it was the expectation that they respond to the call bell right away. The RPNs indicated that if a resident was waiting for more than 20 minutes, that was unacceptable and it could put the resident's safety in jeopardy.

In separate interviews with Nurse Manager (NM) #118, they indicated that they would review a report each morning of the call bell response times for the past 24 hours, and that any call bell, or bed and chair alarms that were ringing for 20 minutes or longer would be indicated on the report. The NM further indicated that they would look to see which PSW was responsible for providing care to that resident at the time, and they would follow up with the respective staff members, by providing re-education. The NM also indicated that if they had to follow up with the same staff members again, they would progress to disciplinary action with the staff members. A review of the above mentioned alarm average response time reports, by the NM indicated that the length of time that staff were taking to respond to the call bells and bed alarms was not acceptable and could pose a risk to the residents.

In separate interviews with Assistant Directors of Care (ADOC) #126, and ADOC #127, they indicated that they would also review the daily reports of the call bell response times and would follow up with the staff that were responsible. Both ADOCs, indicated that the above mentioned call bell response times, were not acceptable, and could put the resident's safety at risk. They further indicated that they continue to follow up with staff, and have started following up with the RPN staff as well. ADOC #126 identified that there are some staff that they keep having to follow up with and have provided disciplinary action, included.

In an interview with the Director of Care (DOC), they indicated that the home had been auditing the call bell response times, and following up with staff for any reports that indicated that the call bells were ringing for more than 20 minutes

before staff responded to them. The DOC indicated that although there had been improvement in the call bell response times, they continue to have call bells that ring for more than 20 minutes, which potentially jeopardizes the safety of the residents. [s. 19. (1)]

The severity of this issue was determined to be a level two, as there was minimal harm/minimal risk. The scope of the issue was a level three, as the incident was widespread. The home has a level four compliance history with related noncompliance with this subsection in the last 36 months with this section of the LTCHA, including;
-Compliance Order #001, issued February 21, 2020, with a compliance due date of April 3, 2020, (2020_746692_0004). (690)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 31, 2020

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:

Health Services Appeal and Review Board and the Director

Attention Registrar Health Services Appeal and Review Board 151 Bloor Street West, 9th Floor Toronto, ON M5S 1S4	Director c/o Appeals Coordinator Long-Term Care Inspections Branch Ministry of Long-Term Care 1075 Bay Street, 11th Floor Toronto, ON M5S 2B1 Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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 26th day of June, 2020

Signature of Inspector / Signature de l’inspecteur :

Name of Inspector / Nom de l’inspecteur : Tracy Muchmaker

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