Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

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

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

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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
Apr 28, 2021	2021_800532_0006	025541-20, 025601-20, 000542-21, 003245-21	Complaint

Licensee/Titulaire de permis

Revera Long Term Care Inc.
5015 Spectrum Way, Suite 600 Mississauga ON L4W 0E4

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

Pinecrest Manor
399 Bob Street P.O. BOX 220 Lucknow ON N0G 2H0

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

NUZHAT UDDIN (532), SARAH INGLIS (767), TAWNIE URBANSKI (754)

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): March 8-10, 12, 13, 16-19, 22-26, 2021.

Log #000542-21 related to infection prevention and control practices; Log #003245-21 related to an allegation of neglect; Log #025601-20 related to Personal Support Services and Log #025541-20 related to improper care and harm.

During the course of the inspection, the inspector(s) spoke with the Administrator, Assistant Director of Care (ADOC), Regional Infection Prevention and Control (IPAC) Consultant, Infection Control Lead, Resident Assessment Instrument (RAI) Coordinator, Physiotherapist, Dietitian, Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Housekeeper, residents and family members.

The inspectors also toured resident home areas, observed resident care provision, dining and resident to staff interaction; and reviewed relevant residents' clinical records and IPAC practices.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Sufficient Staffing

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

- **6 WN(s)**
- **2 VPC(s)**
- **4 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. 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:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

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 a resident was treated with respect and dignity.

A resident required a wheelchair to maintain their activities of daily living.

The resident was not provided their wheelchair over a period of time, despite the device being safe to use. As a result, the resident was not able to participate in their normal activities of daily living (ADLs). This upset the resident, as it was not dignified and infringed upon their right to mobilize within the home.

Sources; Interview with resident, interview with staff and other, resident's plan of care, progress notes. (767)

B) The licensee has failed to ensure that a resident's right to be properly fed and cared for in a manner consistent with their needs was fully respected and promoted.

A resident was observed not receiving assistance or an appropriate assistive device to eat their meal resulting in the resident eating less than 25 percent (%) of their meal.

The resident's right to be properly fed and cared for in a manner consistent with their needs was not fully respected and promoted when a staff did not provide them with the appropriate utensils and assistance to eat their meal.

Sources: resident observation, staff interview, POC documentation and plan of care. (532) [s. 3. (1) 1.]

Additional Required Actions:

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

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 :

The licensee has failed to ensure that a resident was free from neglect by the licensee or staff in the home.

For the purpose of the Act and this Regulation, “neglect” means the failure to provide a resident with the treatment, care services, or assistance required for health safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s.5.

A resident experienced a decline in several areas related to health status over a four month period.

The family expressed concerns about the resident's deteriorating condition days prior to their death.

During the identified period of significant physical decline, the resident was not assessed or monitored appropriately. They were not assessed in person by their physician, nor was there a plan in place for onsite medical coverage. The physician assessment was based on nursing evaluations and vital signs. Despite the physician noting the deteriorating condition of the resident, the resident did not see a specialist.

After the resident passed away, the ADOC completed an investigation into the resident's decline and health status. They identified a lack of communication between the registered nursing staff and a failure to notify the physician and family of the resident's change in status.

Not ensuring the resident was assessed and monitored may have lead to delayed or no treatment, thus contributing to the resident's decline in health status and hospitalization.

Sources: progress notes, e-MARs, plan of care, weights and vitals, resident daily hydration tracking log, interviews with the physician, ADOC, IPAC RN, RD, Falls Lead and other staff. [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. 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 residents were bathed at a minimum of twice a week by a method of their choice.

Residents #007, #008 and #009 raised concerns with an Inspector about not receiving their two baths per week.

A) Resident #007 was to receive a tub bath twice per week.

Record review showed that the resident missed one out of eight scheduled baths (13%) over four weeks and was upset they had not received their scheduled bath.

Sources; interview with the resident, staff, record review of POC tasks and resident's plan of care.

B) Resident #008 was to receive a tub bath twice a week.

Record review showed that the resident missed three out of eight scheduled baths (38%) over four weeks. The resident said they did not receive a bath on the three dates, which upset them.

Sources; Interviews with resident, staff and others, POC tasks, and resident's plan of care.

C) Resident #009 was to receive a tub bath twice per week.

Records showed that the resident missed four out of eight scheduled baths (50%) over four weeks. There was no documentation to support that staff had provided a bath.

The resident was upset and said they did not receive several baths and the baths that were provided were not according to their preference.

In addition, there was no process in place to ensure that staff provided missed baths to the residents.

Not ensuring that the residents were bathed twice a week by a method of their choice was upsetting to the residents and could result in other health concerns.

Sources; Interview with the resident, staff and others and record review.

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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director of Nursing and Personal Care (DONPC) regularly worked in that position on-site.

The home had a licensed bed capacity of 49 beds, requiring the DONPC to be on-site a minimum of 24 hours per week. At the time of the inspection, a DONPC had not worked on-site for the required number of hours since August 23, 2020.

There was limited clinical leadership in the absence of the DONPC.

Not ensuring a DONPC was on-site to provide clinical leadership and oversight posed a potential risk to resident care in the home.

Sources: Interview with staff and others, observations. [s. 213. (1)]

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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

The licensee has failed to ensure that the resident's plan of care related to falls prevention was revised and that different approaches were considered when care set out in the plan of care was not effective.

A resident was considered at risk of falls.

During an identified period, the resident experienced a decline in their health condition and had several falls. When the resident's plan of care related to falls prevention was reviewed, different approaches were not considered.

Failing to update the resident's plan of care concerning falls prevention placed the resident at risk for additional falls and injuries.

Sources: Post fall assessment, plan of care, Fall Lead and other staff interviews. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident 's plan of care related to falls prevention is revised when care set out in the plan of care is not effective, and that different approaches are considered, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure meals were only served to residents when staff were available to assist them.

While residents were isolated to their rooms, staff were observed not providing adequate assistance to the residents that required cuing, encouragement and meal set up.

Resident #004, #005 and #006 required necessary help and support when eating.

Observations identified the following:

A) Breakfast trays were delivered and left in residents #005 and #006's room for approximately 20 minutes before receiving assistance.

B) Lunch trays were delivered and left in residents #005 and #006's room for approximately 40 minutes before the residents received support and assistance with their meal.

C) Resident #004 did not receive any assistance with their lunch and as a result only consumed 25% of their meal.

Sources: observations, interviews with PSWs, Registered Dietitian, Public Health and other staff. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure meals are only served to residents when staff are available to assist them, to be implemented voluntarily.

Issued on this 11th day of May, 2021

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	NUZHAT UDDIN (532), SARAH INGLIS (767), TAWNIE URBANSKI (754)
Inspection No. / No de l'inspection :	2021_800532_0006
Log No. / No de registre :	025541-20, 025601-20, 000542-21, 003245-21
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 28, 2021
Licensee / Titulaire de permis :	Revera Long Term Care Inc. 5015 Spectrum Way, Suite 600, Mississauga, ON, L4W-0E4
LTC Home / Foyer de SLD :	Pinecrest Manor 399 Bob Street, P.O. BOX 220, Lucknow, ON, N0G-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Lisa Stroeder

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Revera Long Term Care Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / 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. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

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

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

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

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

iv. have his or her personal health information within the meaning of the Personal

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

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according

to their mutual wishes, if appropriate accommodation is available.

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

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

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

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

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

Order / Ordre :

The licensee must be compliant with s. 3. (1) 1 and 3. (1) 4 of the LTCHA.

Specifically, the licensee must:

1) Ensure that a resident is treated with courtesy and respect and in a way that fully recognizes the resident's rights to their individuality and respects their dignity. This includes allowing them to safely mobilize within the home, be toileted with the required level of assistance and provided meals as outlined in their plan of care.

2) Ensure that a resident is properly fed and cared for in a manner consistent with their needs.This includes assisting the resident with their meals and providing them the required utensils.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was treated with respect and dignity.

A resident required an wheelchair to maintain their activities of daily living.

The resident was not provided their wheelchair over a period of twenty days, despite the device being safe to use. As a result, the resident was required to stay in bed for extended periods of time, including for meals and toileting. This upset the resident, as it was not dignified and infringed upon their right to mobilize within the home.

Sources; Interview with resident, interview with staff and other, resident's plan of care, progress notes.
(767)

2. The licensee has failed to ensure that a resident's right to be properly fed and cared for in a manner consistent with their needs was fully respected and promoted.

A resident was observed not receiving assistance or an appropriate assistive device to eat their meal resulting in the resident eating less than 25 percent (%) of their meal.

The resident's right to be properly fed and cared for in a manner consistent with their needs was not fully respected and promoted when a staff did not provide them with the appropriate utensils and assistance to eat their meal.

Sources: resident observation, staff interview, POC documentation and plan of care.

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

Severity: There was minimal risk of harm when the rights of the residents were not fully respected and promoted.

Scope: The scope of this non-compliance was a pattern because two of the three residents reviewed during this inspection did not have their rights fully respected and promoted.

Compliance History: Written Notifications (WN) and Voluntary Plans of Correction (VPC) were issued to the home related to different sections of the legislation in the past 36 months. (532)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Jun 04, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / 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 be compliant with s. 19. (1) of the LTCHA.

Specifically, the licensee must:
1) Ensure that residents are not neglected by staff in the home.

2) Ensure that all registered staff are re-educated on the following policies and procedures:

a) Falls prevention and management policy in relation to assessing residents and revising their plan of care when a fall has occurred.
b) Nutrition and hydration policy in relation to re-weighing residents, monitoring fluid intake and referring residents to the Registered Dietitian when needed.
c) Nursing assessments when a resident has sustained a significant change in condition and the process for notifying the physician and other members of the interdisciplinary team as required.

3) Document the education that was provided to staff members including the date and the staff member who provided the education. Keep a record of attendance including staff names and date the education was received.

4) The physician regularly attends the home to provide services, including on-site assessment and evaluation.

5) Develop and implement an auditing tool to ensure that assessments and referrals are fully completed as required for residents with hydration and weight changes, and for residents who sustain a significant change in their condition. The audit is to be completed for a period of three months and include the date of the review, the person responsible, and actions taken, if any, must be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that a resident was free from neglect by the licensee or staff in the home.

For the purpose of the Act and this Regulation, "neglect" means the failure to provide a resident with the treatment, care services, or assistance required for health safety or well-being, and includes inaction or a pattern of inaction that

jeopardizes the health, safety or well-being of one or more residents. O. Reg. 79/10, s.5.

A resident experienced a decline in their health status over a four month period, that included repeated infections, falls, increased pain, confusion, and altered intake.

The family expressed concerns about the resident's deteriorating condition days prior to the resident's hospitalization and subsequent death.

During the identified period of significant physical decline, the resident was not assessed or monitored appropriately. They were not assessed in person by their physician, nor was there a plan in place for onsite medical coverage. The physician assessment was based on nursing evaluations and vital signs. Despite the physician noting the deteriorating condition of the resident, the resident did not see a specialist.

After the resident passed away, the ADOC completed an investigation into the resident's decline and health status. They identified a lack of communication between the registered nursing staff and a failure to notify the physician and family of the resident's change in status.

Not ensuring the resident was assessed and monitored may have lead to delayed or no treatment, thus contributing to the resident's decline in health status and hospitalization.

Sources: progress notes, e-MARs, plan of care, weights and vitals, resident daily hydration tracking log, interviews with the physician, ADOC, IPAC RN, RD, Falls Lead and other staff.

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

Severity: Not ensuring the resident was assessed, monitored and provided appropriate treatment resulted in actual risk of harm.

Scope: The scope of this non-compliance was isolated, as no other incidents of neglect were identified during this inspection.

Compliance History: Written Notifications (WN) and Voluntary Plans of Correction (VPC) were issued to the home related to different sections of the legislation in the past 36 months. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 04, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Order / Ordre :

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

Specifically, the licensee must:

1) Ensure residents #007, #008 and #009 are bathed at least twice weekly and by a method of their choice.

2) Complete a weekly audit to ensure that residents are bathed according to their plan of care. The audit must include the name of the person completing the audit, the date the audit was completed, the results of the audit and actions taken with regards to the audit results. The audit must be kept in the home.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were bathed at a minimum of twice a week by a method of their choice.

Residents #007, #008 and #009 raised concerns with an Inspector about not receiving their two baths per week.

A) Resident #007 was to receive a tub bath twice per week.

Record review showed that the resident missed one out of eight scheduled baths (13%) over four weeks and was upset they had not received their scheduled bath.

Sources; interview with the resident, staff, record review of POC tasks and resident's plan of care. (767)

2. Resident #009 was to receive a tub bath twice per week.

Records showed that the resident missed four out of eight scheduled baths (50%) over four weeks. There was no documentation to support that staff had provided a bath.

The resident was upset and said they did not receive several baths and the baths that were provided were not according to their preference.

Sources; Interview with the resident, staff and others and record review. (767)

3. Resident #008 was to receive a tub bath twice a week.

Record review showed that the resident missed three out of eight scheduled baths (38%) over four weeks. The resident said they did not receive a bath on the three dates, which upset them.

In addition, there was no process in place to ensure that staff provided missed baths to the residents.

Not ensuring that residents #007, #009 and #008 were bathed twice a week by a method of their choice was upsetting to the residents and could result in other health concerns.

Sources; Interviews with resident, staff and others, POC tasks, and resident's plan of care.

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

Severity: There was minimal risk of harm when residents #007, #008 and #009 were not bathed at a minimum of twice a week by a method of their choice.

Scope: The scope of this incident was widespread because three out of the

three residents reviewed during this inspection were not bathed at a minimum of twice a week by a method of their choice.

Compliance History: Written Notifications (WN) Voluntary Plans of Correction (VPC) were issued to the home related to different sections of the legislation in the past 36 months. (767)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 04, 2021

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / 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. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:

1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week.
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week.
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week.
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week.
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Order / Ordre :

The licensee must be compliant with s. 213 of O. Reg 79/10.

Specifically, the licensee must:

1) Ensure the home's Director of Nursing and Personal Care works regularly in that position on site at the home at least 24 hours per week.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the Director of Nursing and Personal Care (DONPC) regularly worked in that position on-site.

The home had a licensed bed capacity of 49 beds, requiring the DONPC to be on-site a minimum of 24 hours per week. At the time of the inspection, a DONPC had not worked on-site for the required number of hours since August 23, 2020.

There was limited clinical leadership in the absence of the DONPC.

Not ensuring a DONPC was on-site to provide clinical leadership and oversight posed a potential risk to resident care in the home.

Sources: Interview with staff and others, observations.

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

Severity: There was limited clinical leadership in absence of the DONPC, which resulted in minimal risk of harm to residents.

Scope: The scope of this incident was widespread because all residents could have been affected by the DONPC not working regularly at the home.

Compliance History: Written Notifications (WN) and Voluntary Plans of Correction (VPC) were issued to the home related to different sections of the legislation in the past 36 months. (767)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 04, 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
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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 28th day of April, 2021

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Nuzhat Uddin

Service Area Office /
Bureau régional de services : Central West Service Area Office