Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Amended Public Copy/Copie modifiée du 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 08, 2019	2018_570528_0007 (A1) (Appeal\Dir#: DR# 115)	019778-16, 033819-16, 000003-17, 000137-17, 028260-17, 001783-18, 003167-18, 031636-18, 032029-18	Complaint

Licensee/Titulaire de permis

Waterdown Long Term Care Centre Inc.
c/o Jarlette Health Services 5 Beck Boulevard PENETANGUISHENE ON L9M 1C1

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

Alexander Place
329 Parkside Drive P.O. Box 50 Waterdown ON L0R 2H0

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

Amended by Wendy Lewis (Director) - (A1)(Appeal\Dir#: DR# 115)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

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NOTE: This report has been revised to reflect a decision of the Director on a review of the Inspector's order(s): CO#003.
The Director's review was completed on April 08, 2019.
Order(s) was/were rescinded and substituted with a Director Order to reflect the Director's review DR# 115.
A copy of the Director Order is attached.

Issued on this 8 th day of April, 2019 (A1)(Appeal\Dir#: DR# 115)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

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

Amended by Wendy Lewis (Director) - (A1)(Appeal/Dir# DR# 115)

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): November 21, 22, 23, 26, 27, 28, 28, 30, December 3, 5, 6, 10, 2018.

This complaint inspection included the following:

i. Complaint log #019778-16 related to falls, pain, and elopement

ii. Complaint log #: 033819-16 related to falls

iii. Complaint log #: 000003-17 related to continence care, medication management, insufficient staffing

iv. Complaint log #: 000137-17 related to insufficient staffing

v. Complaint log #: 028260-17 related to falls

vi. Complaint log #: 001783-18 related to plan of care, hospitalization and change in condition, complaints and concerns process

vii. Complaint Log #: 003167-18 related to plan of care, complaints and concerns process, food production

viii. Complaint Log #'s: 0313636 and 032029-18 related to oral care and complaints and concerns process.

This inspection was completed concurrently with Critical Incident Inspection #: 2018_570528_0008. Non compliance identified in CIS inspection related to LTCHA s. 6(10)(b) is included in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Directors of Care (DOCs), the Nutrition Manager, Staffing Coordinator, Housekeeping/Laundry Manager, registered nurses (RNs), registered practical nurses (RPNs), personal support workers (PSWs), dietary

aides, residents and families.

During the course of the inspection, the inspector(s) observed the provision of care and services, reviewed documents including but not limited to, medical records, staffing schedules, policies and procedures, complaints logs, meeting minutes, investigation notes, and staff files.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Critical Incident Response
Dignity, Choice and Privacy
Falls Prevention
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Sufficient Staffing

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

- **15 WN(s)**
- **10 VPC(s)**
- **3 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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A. Complaint logs # 019778-16 and 028260-17, both submitted in June 2016,

identified concerns related to pain control for resident #021.

The home's 'Pain Management Program' last revised in March 2016, directed staff to screen for pain on admission. Specifically, they were to complete a comprehensive pain assessment on admission (under assessments in Point Click Care).
In addition, a comprehensive assessment was to be completed for worsening or unrelieved pain, identified as a pain score 4/10 on verbal report, numerical or descriptive, or caregiver reported behavioural symptoms of pain.

i. Review of the plan of care for resident #021 identified that the resident had multiple diagnosis with responsive behaviours. Review of the progress notes for resident #021 identified that they had a fall in June 2016. The post fall assessment identified that the resident had a change in status, including pain, which continued after the fall. The resident was sent to hospital with injury.
ii. Review of the medical record did not include a comprehensive pain assessment when the resident was reporting ongoing pain after their fall, as confirmed in an interview with DOC #103.
iii. In addition, when the resident returned back to home with an injury, a comprehensive pain assessment was not completed, as confirmed in an interview with DOC #103. (528)

B. Complaint log # 033819-16, submitted in December 2016, identified concerns related to falls management of resident #018.

i. Documentation in the progress notes for resident #018 identified the resident was having pain on several occasions in June and July 2018.

ii. Pain was also documented in the resident's progress notes after a fall that occurred in December 2017, requiring a new order for an opioid analgesic as needed for pain. In January 2018, registered staff documented the resident displayed non verbal signs of pain, which were also reported by the SDM. Although, resident #018 had documented pain and behavioural symptoms of pain, as identified in the progress notes, a comprehensive pain assessment was not completed.

iii. During an interview with Inspector #107, registered staff #120 who routinely cared for resident #018, identified resident #018 was in pain and that a comprehensive pain assessment was not completed as they were unaware of the

requirement to complete the assessment form until recently.

iv. During an interview with Inspector #107 the Director of Care (DOC) stated staff were to complete a comprehensive pain assessment when a resident had a worsening of pain or there was an increase or decrease in pain medication. The Inspector asked the DOC to review resident #018's pain assessments on Point Click Care (PCC) and the DOC confirmed there were none available on PCC for the time period reviewed.

v. The LTC home's policy, "Resident Rights, Care and Services – Required Programs – Pain", effective date of September 2013 and revised date of March 2016, also identified that every resident with worsening pain or unrelieved pain, as identified by a pain score of 2 or 3 on RAI MDS, or a score of 4/10 on verbal self report of pain – numerical or descriptive, or care giver/family reported behavioural symptoms of pain receives a comprehensive pain assessment completed in Point Click Care.

vi. Resident #018 had documented pain and behavioural symptoms of pain greater than a four on several occasions in December 2017 and July 2018; however, a comprehensive pain assessment was not completed using a clinically appropriate assessment instrument specifically designed for pain, as required by the home's policy.

viii. Pain Screening Notes in the progress notes for resident #018 in July 2018, did not have all sections of the note completed consistently, and the resident's pain was not comprehensively assessed or screened for. Notes were missing data related to current pain management interventions, effectiveness of interventions, and evaluation and intervention initiated for pain greater than 4 or severe. Many of the notes identified the resident was demonstrating pain, however, the effectiveness of interventions section was incomplete or contradictory. The notes did not reflect an evaluation of previous interventions and the underlying causes of pain, or any interventions implemented to relieve the pain.

A comprehensive pain assessment was not completed for resident #018 using a clinically appropriate assessment instrument specifically designed for the assessment of pain when the resident had pain. (107)

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 O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation; O. Reg. 79/10, s. 31 (3).
(b) set out the organization and scheduling of staff shifts; O. Reg. 79/10, s. 31 (3).
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident; O. Reg. 79/10, s. 31 (3).
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and O. Reg. 79/10, s. 31 (3).
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A. Complaint log #000137-17, submitted in January 2017, identified concerns related to staffing shortages in the home.

B. Review of the home's 2017/2018 Complaint Log, identified numerous concerns about staffing shortages effecting resident care.

C. On an identified day in November 2018, the provision of care was observed on specific home area. Although, the home area was working at their full complement with four PSW staff and one RPN, meal service was delayed in starting.
i. Review of PSW job routines confirmed that beverage cart was to start at a specified time and meal service at a specified time.
ii. Meal service was started on the identified home area 30 minutes late. There was no reported cause of the service starting late; however, resident #028 and #029 in the dining room were visibly upset and stated that "it was talking too long", referring to meal start time, and stated that delayed start time was a regular occurrence.

D. On an identified day in November 2018, the provision of care was continuously observed on an identified home area for more than two and a half hours:
i. The daily complement for PSW staff included four PSWs on day shift; however, due to staffing shortages the home area was working with three PSW's
ii. PSW staff were observed providing continuous care to residents without any breaks.
iii. At a specified time, 12 residents were observed in bed.
iv. Resident #027 was heard calling out for help. When the LTC Inspector #528 entered the room, the resident was observed sitting in a state of undress. Interview with the resident confirmed that they had needed staff to help with activities of daily living. The resident stated they had notified staff that they needed help "about 10 minutes ago". At that time, the LTC Inspector activated the call bell to alert staff that the resident needed assistance, the call bell went unanswered. Co-residents were leaving their rooms to the dining room and were distressed seeing resident #027 in a state of undress. Approximately 30 minutes later, PSW #137 assisted resident #027 with personal care. Review of the plan of care identified that the resident required assistance of one staff for activities of daily living (ADLs). Resident #027 was not provided with the assistance to complete personal care, and after waiting for approximately 40 minutes, resident #027 was exposed to co-residents in a state of undress.
v. Interview with resident #026, who was in bed revealed they had been dressed approximately two hours prior, and had since been waiting for additional assistance. The resident stated that they had been waiting too long. The resident was assisted with personal care. Approximately 30 minutes later, resident #026

was heard calling out to staff. Interview with the resident, at that time, identified that they were required the assistance of staff. Review of the plan of care for the resident identified that they required extensive assistance of one staff member and were dependent on staff for mobility. The resident was assisted, approximately 20 minutes later, after the LTC Inspector notified staff that the resident was still waiting. Resident #026 was not provided with assistance as required in their plan of care for personal care and mobility, in a timely manner.
vi. PSW #133 was observed walking up and down the hallways, looking for staff. Interview with PSW #133 confirmed that resident #024 had been waiting for an unidentified amount of time but they had gone in the room because the resident was distressed. In addition, PSW #133 stated that staff pressed the call bell to alert other staff that they needed assistance; however, when they were short staffed no one was around to answer the alarm and they ended up running up and down the hall looking for a second person for lifts and transfers. Review of the plan of care for resident #024 identified that they required the assistance of two staff and a mechanical lift. Resident #024 had to wait an extended period of time causing them distress.
vii. At a specified time, a call bell was ringing. PSW #118 went to the room and identified that it was PSW #133 who alerted the bell for staff assistance with a resident to complete a lift, which required two staff. PSW #118 was unable to provide the necessary assistance. PSW #133 waited an additional 15 minutes, until another staff member arrived to transfer the resident.
viii. At a specified time, only four residents were in the dining room, meal service was not started according to the homes scheduled meal times approved by the Resident Council.
ix. At a specified time, RPN #140 confirmed that resident #028 had received a medication and had not received a required intervention in a timely manner.
x. At a specified time, seven residents were in the dining room.
xi. Beverages and meal service was started on in the dining room for the identified home area approximately 30 minutes late.
xii. Three residents in the dining room, were upset that meal service was so late and stated that it has gotten worse over the last three years.
xiii. At a specified time, LTC Home Inspector #528 observed PSW #137 and #118 use a mechanical lift to get a resident out of bed. Confirmed in an interview with the Administrator, that PSW #118 was not to complete safe lifts for residents. The Administrator also confirmed that two staff were required to assist with mechanical lift to complete safe transfers of residents.
xiv. Meal service was started 40 minutes late in the identified dining room.
xv. At a specified time, resident #029 entered dining room and appeared upset.

They had stated "they forgot me".
xvi. At a specified time, the hairdresser began cleaning dirty dishes from the tables. Shortly after, resident #030 stood up and stated their frustrations with the late meal service and felt rushed as they had not coffee.
xvii. PSW staff started to serve coffee and tea, approximately one hour late.
xviii. The dietary aide was observed putting food away. Observed PSW #137 tell the dietary aide that meal service was not finished.
xix. Resident #016 had not yet been fed their meal, which was placed in front of them approximately 40 minutes earlier. When the LTC Inspector asked about the resident, PSW #137 reported that they were short staffed, meal service was no longer available, and the resident would be fed an alternative instead. Review of the plan of care for the resident identified that they were a nutritional risk, were to receive nutritional supplements, and required total assistance with eating. Resident #016, who was high nutritional risk, was not provided the complete meal for breakfast or the assistance required to eat their meal.
xxi. DOC #102 and #103 were observed serving the beverage cart to residents on the identified home area. Interview with PSW #115 and PSW #117 during the course of the inspection revealed that if they were short staffed sometimes they did not have time to do the beverage/snack cart, resulting in residents not receiving snacks and beverages, as required to meet their nutritional needs. Review of job routines for PSW staff did not include beverage cart service by the Directors of Care.

E. On an identified day in November 2018, the provision of care was continuously observed on an identified home area, which was working with one PSW less than the required complement.
i. PSW #111 was observed transporting resident #030 from another home area. When they arrived on the identified home area they asked "Where is everyone?". It was at that time, DOC #102 entered the home area to implement interventions for resident #030. Interview with PSW #111 confirmed that resident #030 was found on another home area. Review of the plan of care for resident #030 identified that they were a risk for falls and directed the staff to know where the resident was at all times. Interview with RN #118 confirmed they did not know the whereabouts of resident #030, as required in their plan of care.

F. On an identified day in November 2018, review of staff complement for two home areas identified that the areas were fully staffed; however, beverage cart for meal service started 45 minutes following the scheduled start time. Multiple residents were visibly upset. Resident #028 and #029 specifically stated they

were dissatisfied with the meal start time.

G. On an identified day in November 2018, the provision of care was continuously observed on and identified home area for over two hours. The identified home area was working short one PSW staff member.
i. Thirty minutes after meal service was scheduled to start, there were no residents in the dining room. The DOC #104 was observed portering residents to the dining room.
ii. Fifteen minuted later, the Administrator entered home area and began portering residents to the dining room. The staff coordinator was observed entering dining room and started beverage cart for the identified home area, then asked staff from the neighbouring home area to come help get the residents into the dining room. One PSW from the neighbouring home area entered the identified home area to help with transfers.
iii. Meal services started on the identified home area, an hour after the scheduled start time.
There was insufficient staff on the floor to ensure residents were assisted to the dining room in a timely manner, and therefore, dining service started an hour late.

H. Review of the daily complem of PSW staff from August to November 2018 and an interview with the staffing coordinator confirmed the following:
i. In August 2018, PSW staff worked short on approximately eight occasions on day shift, three occasions on evening shift, and seven occasions on night shift.
ii. In September 2018, PSW staff worked short approximately 10 occasions on day and evening shift, and on one occasion on night shift. The schedule was not reviewed from September 23 to 29, 2018, as the home did not provide the records.
iii. In October 2018, PSW staff worked short on approximately 15 occasions on day shift and three occasions on evening shift.
iv. In November 2018, PSW staff worked short on approximately 18 occasions on day shift, one occasion on evening shift and on six occasions on night shift.
Interview with the staffing coordinator confirmed that multiple staff were on modified duties or not available for scheduling.

I. Review of bathing records for residents #017, #024, and #025. The following was identified:
i. Review of the written plan of care for resident #024 identified that they required assistance with bathing. Review of Point of Care (POC) bathing records, from

August to November 2018, revealed that the resident did not receive their bath on three occasions.
ii. Review of the written plan of care for resident #025 identified that they required assistance with bathing. Review of POC bathing records, from August to November 2018, revealed that the resident did not receive their bath on three occasions.
iii. During the course of the inspection, interviews with PSW #113, #136 , #133, #137, #139 identified that the home "always" worked short and therefore bathing of residents did not get done.
iv. Interview with DOC #102 confirmed that if bathing was missed due to short staffing, extra staff would be called in the following day to make up missed baths. However, interview with PSW #138 by LTC Inspector #107, identified that the plan to call in staff was not always effective and that they had been called in that day to complete baths that had been missed due to short staffing. PSW #138 expressed concerns that they would not be able to bathe all of the scheduled residents.

J. Throughout the course of the inspection, inspectors were approached by staff on several occasions to discuss their concerns related to staffing shortages on all shifts. Interviews with PSW staff #110, #113, #114, #115, #117, #133, #136, #137, #139 and #139 all expressed concerns related to short staffing, within relation to effecting care to the residents, including bathing and wait times for assistance. Registered staff #119, #123 and #125 all expressed concerns related to the regularity in which PSW staff worked short.

K. Interview with DOC #102 revealed changes in the staffing pattern that included in October 2016, additional PSW staff were added to each shift, for dementiability and supporting the residents in the home. However, in August 2018, one full time PSW position was removed from the evening and one from the day shift; and in October 2018, a full time PSW position was removed from the nights shift. When asked why the staffing was removed permanently from the schedule, the DOC indicated that it was a budgetary decision.

L. Interview with DOC #102 identified that the home does attempt to fill vacancies in the schedule and overtime provided to staff in an effort to ensure the staffing complement is met. They did identify that they continue to work to retain staff by hosting regularly occurring staff appreciation events, take on students for early recruitment, host and attend job fairs, and are currently conducting interviews for new PSW and registered staff. (528) [s. 31. (3)]

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

Specifically failed to comply with the following:

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

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

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was provided to the resident as specified in the plan.

Complaint logs #019778-18 and #028260-17, were submitted in 2016 and 2017, related to multiple concerns including but not limited to, CIS #26610999924-17 and falls management.

The plan of care for resident #016 identified that the resident was at a risk for falls and required a device when in bed. Review of the CIS report revealed that on an identified day in November 2017, the resident had an unwitnessed fall, which resulted in injury. Review of the post fall huddle documented that the device was

applied but not working. Interview with DOC #103 confirmed that the device did not activate and therefore, the intervention was not in place.

The plan of care for resident #016 was not provided to the resident as specified in the plan, related to the falls prevention.

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

A. Complaint log # 031636-18, received in November 2018, identified care concerns related to care for resident #022.

Review of the written plan of care for resident #022 identified that the resident required assistance with care and included specific interventions for staff. Review of the physician orders revealed that in October 2018, there was a change in resident status. Interview with DOC #103 revealed that several days later, the substitute decision maker (SDM) and power of attorney (POA) expressed care concerns resulting in potential harm. Interview with RPN #134 confirmed that the day before the incident, the SDM had requested a change in a care intervention but the written plan of care was not updated to include the new directions. Interview with RPN #134 and DOC #103 confirmed that there was no reassessment of the resident, related to concerns of potential harm.

B. Complaint log # 019778-16, submitted in June 2016, log # 028260-17 submitted in December 2017, both described concerns of pain management for a resident.

Review of the progress notes for resident #021, identified that in June 2016, they had a fall. Several days later, they were sent to hospital for assessment of their injury. The post fall assessment reported that the resident had identified pain post fall. The following day, registered staff documented that resident had pain. A specialized assessment was completed two days after the fall, which recommended a change in transfer status until further assessment. Interview with DOC #102 and DOC #013 confirmed that registered staff did not call the physician in a timely manner, related to ongoing documented pain post fall, and therefore, the resident was not reassessed and the plan of care was not revised when the resident's condition changed. (528)

C. Complaint log # 001783-18, submitted in January 2018, identifying concerns related to plan of care not being followed.

i. Review of the health record for resident #014 identified that the resident had multiple diagnosis and was in and out of hospital.
ii. Review of the progress notes confirmed that in January 2018, concerns were brought forward to the home related to eating preferences. Review of the plan of care also identified that later that month, the resident was sent out for treatment and returned back to the home with orders for specialized care. Review of the written plan of care identified that it was was not updated until after the resident deceased, related to eating preferences and specialized care. Interview with DOC #103 confirmed that the written plan of care was not updated when the resident's care needs changed. (528)

D. Complaint log #001783-18, submitted in January 2018, identified concerns related to assessment of resident #014 when there was a change in condition.

Review of the health record identified that resident #014 had multiple co-morbidities with multiple exacerbations.

Review of progress notes revealed that after several changes in the resident's medications by the physician and change in requirements of treatments, they were sent to hospital for treatment. Upon return to the home several days later, the physician documented specific monitoring requirements when the condition of the resident had changed.
The following month, on an identified day, the resident had a change in treatment requirements. The progress notes did not include consistent monitoring requirements outlined by the physician in the days prior to hospital admission. Interview with DOC #103 confirmed that monitoring requirements were not consistently completed by registered staff related to monitoring changes in the resident's status. (528)
When the resident returned home, the physician assessment, documented specific signs and symptoms to monitor. Over the next few days, the progress notes from registered staff did not document any findings related to the physicians recommended assessment. Interview with DOC #103 confirmed that the progress notes did not include reassessment of the resident, as outlined by the physician. In addition the written plan of care was not updated to reflect the physicians recommendations. (528)

E. Critical Incident System #2861-000021-16, log # 032131-17, related to resident allegations of sexual abuse.

The licensee failed to ensure that resident #010 had their plan of care reviewed and revised when the resident's care needs changed.

Documentation in resident #010s progress notes on an identified day in November 2016, identified the resident required two specific intervention related to responsive behaviours. During interview with the Director of Care (DOC) #102 confirmed that the written plan of care was not updated to include the interventions at the time they were implemented

Resident #010 did not have their plan of care revised to include specific interventions related to responsive behaviour monitoring.

Additional Required Actions:

(A1)(Appeal/Dir# DR# 115)
The following order(s) have been rescinded: CO# 003

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 plan of care is provided to the resident as specified in the plan, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee did not ensure that actions taken with respect to a resident under the falls prevention and management program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

Complaint log #0033819-16, related to concerns of falls management for resident #018.

The licensee did not ensure that actions taken with respect to resident #018 under the falls prevention and management program, required under O.Reg. 79/10, s. 48, including interventions and the resident's responses to interventions were documented.

Resident #018 had a plan of care that required falls prevention strategies to be in place. The resident required specified devices.

From February to September 2017, the post fall assessments did not identify if the devices were in place at the time of the resident's falls and several notes recorded that the devices were not working.

Documentation in the resident's progress notes in December 2017, identified the concerns were submitted to the home related to the residents falls.

During interview Co-DOC #103 identified that some of the devices were not working. The Co-DOC confirmed that they had email correspondence with the company about the devices and were unable to confirm if the required strategies were in place at the time of the identified falls.

Resident #018 required falls management strategies to prevent further falls; however, documentation did not include a reassessment of the falls prevention strategies in place at the time of the falls and if the strategies were implemented and effective at the time of the identified falls. [s. 30. (2)]

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 actions taken with respect to a resident under the falls prevention and management program, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Complaint log # 000137-17, submitted in January 2017, identified care concerns with resident #017. In a follow up call with the complainant on November 20, 2018, they identified that their main concern was that the home did not have enough staff.

I. Review of bathing records for residents #017, #024, and #025. The following was identified:
i. Review of the written plan of care for resident #024 identified that they required assistance with bathing. Review of Point of Care (POC) bathing records, from August to November 2018, revealed that the resident did not receive their bath on three occasions.
ii. Review of the written plan of care for resident #025 identified that they required assistance with bathing. Review of POC bathing records, from August to November 2018, revealed that the resident did not receive their bath on three occasions.
iii. During the course of the inspection, interviews with PSW #113, #136 , #133, #137, #139 identified that the home "always" worked short and therefore bathing of residents did not get done.
iv. Interview with DOC #102 confirmed that if bathing was missed due to short staffing, extra staff would be called in the following day to make up missed baths. However, interview with PSW #138 by LTC Inspector #107, identified that the plan to call in staff was not always effective and that they had been called in that day to complete baths that had been missed due to short staffing. PSW #138 expressed concerns that they had a total of 10 residents to bathe but they were usually only able to complete four to five baths in a shift.

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 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

1. The licensee failed to ensure that staff used safe transferring and positioning devices or techniques when assisting the resident.

A. Complaint logs # 019778-16, submitted in June 2016, described concerns of pain management for a resident.

i. Review of the progress notes for resident #021, identified that in June 2016, they had a fall with injury. The post fall assessment reported that the resident had identified pain. The following day it was documented that the resident had pain and change in status. A specialized assessment was completed days after the fall and recommended that staff change the device that was used for transferring until further assessment was done. At that time, the physician was notified of the resident's ongoing pain post fall. Staff continued to use an unsafe device for transferring, despite ongoing signs of pain and change in status. Review of the homes investigation notes and interview with DOC #102 confirmed that staff did not safety transfer resident #021. (528)

B. On an identified day in November 2018, LTC Homes Inspector #528 observed PSW #137 and #118 use a device to transfer a resident.
Interview with PSW #118 confirmed they were not to participate in lift and transfers. Interview with PSW #137 confirmed that the home area was working short one PSW. Confirmed in an interview with the Administrator, that PSW #118 was not to participate in lift and transfers.

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 staff use safe transferring and positioning devices or techniques when assisting the resident, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when the resident had fallen, the resident had been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

Complaint log # 019778-16, submitted June 2016, identified concerns related to falls.

The plan of care for resident #016 identified that the resident was at risk for falls and required an intervention. Review of the CIS report revealed that on an identified day in November 2017, the resident had a fall with injury. The post fall assessment completed by RN #123 did not include any documentation related to range of motion or notification of POA. Review of the plan of care included a follow up assessment of the resident by registered staff the following shift, resulting in a transfer, at which time, the POA was notified of the fall. Interview with DOC #102 confirmed that RN #123 did not assess resident #16's range of motion and did not notify the substitute decision maker (SDM), as required as part of the post fall assessment. (528) [s. 49. (2)]

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 when a resident has fallen, the resident has been assessed and, if required, a post-fall assessment been conducted using a clinically appropriate assessment instrument that was specifically designed for falls, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (3) The licensee shall ensure that all food and fluids in the food production system are prepared, stored, and served using methods to,
(a) preserve taste, nutritive value, appearance and food quality; and O. Reg. 79/10, s. 72 (3).
(b) prevent adulteration, contamination and food borne illness. O. Reg. 79/10, s. 72 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods that preserved taste, nutritive value, appearance and food quality and prevented food borne illness.

In November 2018, at a specified time, Inspector #107 observed Dietary staff #127 pureeing ham and flat iron beef steak and putting the containers into the refrigerator for cooling. The staff member stated that they cooked the items, pureed or minced them right after cooking, then put the items into the refrigerator, and then would heat them up in the steamer before the supper meal. The regular texture ham and beef steak were in the oven hot holding until the supper meal (over 3.5 hours).

Dietary staff #127 stated that the ham and beef go into the oven about 1330 hours and come out around 1620 hours. At 1530 hours the minced and pureed items go into the steamer and stay there until 1620 hours when the items are transferred to the steam table for the supper meal at 1655 hours.

The recipe for the ham stated a cook time of 10-15 minutes and the flat iron beef steak required a cook time of 16-20 mins and directed staff not to overcook. Directions on the recipe directed staff to ensure that the food temperature was taken every two hours during hot holding and if cooling the product it must reach 70 degrees Fahrenheit (F) or 21 degrees Celsius (C) within two hours and then from there the temperature must drop to 40 degrees F or 4 degrees C within four hours.

Dietary staff #127 stated that the temperatures were checked once while hot holding in the afternoon and prior to service. The staff stated they did not check the temperatures of the minced and pureed foods while they were cooling in the refrigerator. The minced and pureed foods in the refrigerator were in deep containers and some items had lids over them. An ice bath was not used. Inspector #107 probed the minced and pureed foods in the refrigerator at 1420 hours. Most of the containers were close to 21 degrees C; however, one container of pureed ham (tall container with lid) had a temperature of 31.7 degrees C. The time of two hours had not passed; however, temperatures were not taken by staff to ensure the safety of the foods being cooled. Dietary staff #127 was notified of the temperatures.

Recipes identified that long hot holding times could affect food quality; however, did not specify actual times. Foods were hot held for over 3.5 hours prior to meal service and then potentially another hour during meal service. Residents #032 and #033 voiced concerns about food quality to the Inspector in November 2018 during the lunch meal service.
The licensee failed to ensure that all food and fluids in the food production system were prepared, stored, and served using methods that preserved taste, nutritive value, appearance and food quality and prevented food borne illness. [s. 72. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all food and fluids in the food production system are prepared, stored, and served using methods that preserve taste, nutritive value, appearance and food quality and prevent food borne illness, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Specifically failed to comply with the following:

s. 77. (1) Every licensee of a long-term care home shall ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2) for,
(a) the preparation of resident meals and snacks; O. Reg. 79/10, s. 77 (1).
(b) the distribution and service of resident meals; O. Reg. 79/10, s. 77 (1).
(c) the receiving, storing and managing of the inventory of resident food and food service supplies; and O. Reg. 79/10, s. 77 (1).
(d) the daily cleaning and sanitizing of dishes, utensils and equipment used for resident meal preparation, delivery and service. O. Reg. 79/10, s. 77 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2).

Based on a census of 128 residents (home has more than 97% occupancy), the home is required to provide 403 hours per week or 806 hours per two week period of Food Service Worker time. Due to multiple staff call ins and unfilled shifts the minimum number of Food Service Worker hours was not consistently being provided by the home.

The current Nutrition Manager (#145) started working at the home the first week of November 2018. Prior staffing schedules were provided to the Inspector, however, the Inspector was unable to verify the information on those schedules as the Nutrition Manager (#146) was not available The Nutrition Manager (#145) was able to confirm the information for staffing schedules in November 2018. The

Nutrition Manager (#146) was working in the position of Dietary Aide to fill some hours, however, the schedule did not reflect the number of hours provided in each position (Nutrition Manager versus Dietary Aide). A schedule indicating Nutrition Manager #146's hours working in the role of Dietary Aide in October 2018, was provided to Inspector #107 in December 2018.

The Nutrition Manager (#145) had been working in the role of both Nutrition Manager and Dietary Aide to fill many of the unfilled shifts; however, their current level of work is unsustainable and it is not clear from documentation that the minimum number of hours for the Nutrition Manager role are also being completed as required. Shift hours worked in each role were not being recorded so Inspector #107 was unable to verify how many hours were being completed in each role, other than through verbal statement by Nutrition Manager #145.

Based on staffing schedules and shift hours provided to Inspector #107, the Inspector calculated the following shortages:

September 2018:
Total hours scheduled = 709.5
Short 95.5 hours per 2 weeks.

October 2018:
Total hours scheduled = 666 hours
Short 140 hours per 2 weeks.
The previous Nutrition Manager provided 24 hours in the role of Dietary Aide resulting in shortage of 116 hours per 2 weeks.

October 2018:
Total hours scheduled = 660 hours
Short 146 hours per 2 weeks

October 2018 - November 2018:
Total hours provided = 804.5
Short 1.5 hours per 2 weeks. 37.5 hours of training shifts were included in this 2 week period.

November 2018:
Total hours provided = 794.5 hours (includes 52 on-site hours provided by the Nutrition Manager working in the position of Dietary Aide and 34 hours of training

shifts)
Short 11.5 hours per 2 weeks

During interviews with Dietary staff #130, #136, #129, and #132, PSW #113, 136, and #137, and resident #020, identified concerns about a shortage of Food Service Worker hours resulting in delayed meal times, significant increase in duties to cover for staff shortages, and duties (such as cleaning, washing pots, cleaning carts, sanitizing and cleaning up) not being completed due to staffing shortages. All of the above staff interviewed identified that the staffing shortages had been going on for a significant amount of time (months).

As per the Nutrition Manager (#145) in November 2018, dietary staff were to receive three training days in the kitchen for every shift prior to working independently. According to the staffing schedule for November 12-25, 2018, Dietary staff #130 was scheduled for two training days prior to an independent shift. Dietary staff #130 voiced concerns to Inspector #107 about lack of staff to provide orientation for new staff.

The posted start time for the breakfast meal was 0830 hours. On specified dates in November 2018, Inspector #528 observed the breakfast meal on an identified home area, which started late. Food Committee Meeting minutes for September 2018, identified resident concerns with late meal service.The posted start time for the lunch meal service was 1200 hours. On an identified day in November 2018, Inspector #107 observed the lunch meal to start over 15 minutes late. Resident #016 and #020 voiced concerns to Inspector #107 about late meal service at breakfast and lunch meals.

At the time of inspection, Dietary Aides #129, #130 and #126 voiced concerns about the removal of the second floor dishwasher, as it required them to transport dishware up and down between floors. The task required additional time and effort. The staff also stated that once the additional dishware was brought to the main kitchen for washing, the dishwasher was often being used and resulted in further delays to job routines. The removal of the dishwasher with the home consistently short on dietary staffing hours impacted on staff's job routines and ability to provide clean dishes.

The licensee failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2), resulting in delayed meal times, significant increase in duties to cover for staff

shortages, reduced orientation for new staff, and duties not being completed (such as cleaning, washing pots, cleaning carts, sanitizing and cleaning up). [s. 77. (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 there are sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2), to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

Complaint log # 000003-17, submitted on January 2017, described a medication incident.

The home's policy 'Administration of Medication', revised July 2017, directed registered staff to apply the "rights" of medication administration including, right resident (verified by two resident identifiers; right medication; right reason; right dose; right frequency; right route; right site; right time).

A. Review of Medication Incident Form revealed that in December 2016, resident #017 received incorrect medication, resulting in no documented harm to the resident. Review of the electronic medication administration record (eMAR) confirmed that the medications had not been prescribed for the resident. Interview with DOC #102 confirmed that on the identified day, the registered staff did not apply the "rights" of medication administration for resident #017, ensuring that they had the right resident.

2. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

Review of the plan of care for resident #021 identified a progress note in July 2016, which described a medication incident involving the resident. Interview with RPN #135 confirmed that on the identified morning, the resident received an opioid analgesic, which was not in accordance with the original orders. Review of the medication incident form and interview with RPN #135 confirmed that the medication, was not administered to resident #021 in accordance with the directions as ordered for the physician (528) [s. 131. (2)]

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 the following:

a. that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident

b. that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident was taking any drug or combination of drugs, including psychotropic drugs, there was monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs.

Plan of care for resident #021 identified that the resident had a history of responsive behaviours. Interventions on the electronic medication administration (eMARS) were reviewed and a progress note from the registered staff revealed that the resident appeared to be on a reasonable amount of pain medication and would be frequently monitored. Review of the monitoring documenation did not include consistent description of the residents behaviours. Interview with DOC #103 confirmed, that the monitoring was not completed related to the effectiveness of the medications on resident #21's responsive behaviours, as required in the resident's plan of care. (528) [s. 134. (a)]

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 when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program.

A. The homes policy 'Additional Precautions', outlined that equipment should be dedicated to a resident wherever possible. Furthermore, "Decision Tree for Management of Residents Colonized with MRSA', recommended equipment dedication to single resident use.

i. Review of the health record for resident #035 identified that the residents had history of infection with an antibiotic resistant organism and required use of a device. Review of the written plan of care revealed that they were to use their own device, which was to be kept in the room.

ii. Observations of the resident's room were made on two identified days in November 2018; however, there was no device noted. Interviews with PSW #110 and 113 confirmed that the resident used two different devices and was to use their own, and also identified that they had not seen the devices for "weeks". Interviews also confirmed that staff had used the device on the unit to get the resident out of bed on both mornings, and that the device was shared with other residents on the floor.

iii. Interview with DOC #102 and DOC #103 confirmed that the home had supplied the resident the specified devices about three weeks prior. Interview with Laundry Management staff #108, as well as review of tracking logs, confirmed that they had labelled the devices and sent them back to the floor.

iv. Interview with PSW #113 confirmed that the devices were found on another home area and returned to the resident. Interview with DOC #102 confirmed that staff did not participate in the implementation of the infection prevention and control program when they misplaced resident #035's dedicated device.

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 staff participate in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #13: 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 failed to ensure that the dietary department and dietary equipment was kept clean and sanitary.

Complaint log #003167-18, submitted February 2018, submitted concerns related to the cleanliness of beverage and snack carts.

In November 2018, Dietary staff #132 was pushing a cart of clean mugs and cups through the hallway to the servery. The cart was visibly soiled with dried liquid spills, a large amount of crumbs and debris, dried on material on the handles and over the surface of the cart. The staff member stated they hadn't noticed that the cart was dirty and had just grabbed the first cart. The staff member stated they would clean it after they dropped off the cups.

In November 2018, the snack cart on home area one was soiled with dried on debris on the side posts and on the handle and by the wheels of the cart.

In November 2018, Dietary staff #131 was taking carts with clean dishes to the servery. The cart had a significant amount of dried on debris on the sides and bottom of the cart. The Dietary Aide acknowledged the debris and stated that carts were to be cleaned every time they go and drop off dirty dishes in the kitchen.

In November 2018, a cart carrying clean coffee carafes, being delivered to the second floor, was observed with semi dried on lettuce on the top part of the cart, what appeared to be a crushed raspberry and raspberry juice on the bottom shelf, dried on food on various other parts of the cart. Dietary Aide #129 confirmed the cart was soiled and stated the carts were supposed to be cleaned on the evening shift.

Inspector #107 then went to the kitchen where there was another soiled cart with a pan on top (using this for food being prepared). The cart appeared heavily soiled with a large amount of dried on food on the surfaces of both the middle and bottom shelf and sides of the cart.

Another cart in the clean dish area (contained a bin with clean plastic cups) had numerous crumbs on the bottom shelf, dried on liquid in areas, and the cart appeared quite soiled. Dietary staff member #128 stated that evening shift was supposed to clean the carts but had not. The staff member confirmed the cart appeared soiled.

Inspector #107 showed the soiled carts to the Nutrition Manager (#145) who acknowledged the soiling and stated that staff were supposed to do deep cleaning whenever they brought the carts back to the kitchen. The Nutrition Manager (#145) stated they would ensure that this task was completed in future.

Cleaning of the carts was included in the Dietary staff job descriptions. During interview in November 2018, Dietary staff #126 stated that the New Nutrition Manager was going to put back the shift for cleaning as this wasn't getting done. They stated that staff couldn't do the cleaning when they were short staffed.
The Nutrition Manager (#145) stated in November 2018, that they were following up with the cleaning duties as it had been difficult with short staffing to get the duties completed.
The home also allowed alterations to be made to its equipment that did not maintain or improve upon the functional aspects of the home and equipment. With the home consistently short on dietary staffing hours, the removal of a

dishwasher from the second floor impacted the functional aspects of the home, resulting in dishes that were visibly soiled.
During interview with the Administrator (#101) in December 2018, they stated that a booster was purchased and provided for the kitchen dishwasher; however, a booster was not provided for the second floor dishwasher and it was taken out of service. In December 2018, Inspector #107 confirmed the dishwasher had been completely removed from the second floor servery.

Dishes were observed to be visibly unclean during this inspection. Inspector #528 identified soiled cups, mugs, dishes for the morning beverage cart and lunch meal service in November 2018. While serving beverages, PSW #116 confirmed the items on the cart were not clean. Dietary Aide #134 confirmed there were numerous soiled items and agreed that there were approximately 25-50% of the plates, mugs, and bowls for the lunch meal service were not clean. Resident #023 voiced concerns about dirty dishes to Inspector #107 in November 2018. Food Committee Meeting minutes from September 2018 identified dirty cutlery and mugs with a compliance date of October 2018.

The licensee failed to ensure that the dietary department and dietary equipment was kept clean and sanitary. [s. 15. (2) (a)]

WN #14: 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. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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 failed to ensure the communication of the seven day menus to residents.

In November 2018, resident #011 voiced concerns to Inspector #107 that the weekly menus posted did not reflect what was actually being served.

In November 2018, the posted menus in a specified home area reflected week #2 which did not correspond with what was being served to residents. The Nutrition Manager (#145) stated that they were currently serving week #3 of the menus and noted that the posted menu did not reflect the current week (Week #3 menu).

In December 2018, the weekly menu posted outside dining rooms on specified home areas stated week #3. The home was serving week #1 Wednesday. The posted weekly menu had not been updated and was not being communicated to residents. The daily menu was also not current, however, the daily menu was being communicated to residents through a visual demonstration plate shown to residents at their table. [s. 73. (1) 1.]

2. The licensee failed to ensure that no resident who required assistance with eating or drinking was served a meal until someone was available to provide the assistance required by the resident.

In November 2018, breakfast meal service was observed on a specified home area. Resident #016 was served hot cereal at approximately 0910 hours. At 0947 hours, the LTC Inspector #528 asked about the resident, who had still not been fed their cereal. Interview with PSW #137 confirmed that the resident required total assistance eating and was not provided assistance with eating when the meal was served. [s. 73. (2) (b)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances. O. Reg. 79/10, s. 101 (1).
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home was dealt with as follows:
1. The complaint investigated and resolved where possible, and a response that complied with paragraph 3 was provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation was commenced immediately.
2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint was provided within 10 business days of receipt of the complaint including the date by which the complainant could reasonably expect a resolution, and a follow-up response that

complied with paragraph 3 was provided as soon as possible in the circumstances.
3. A response was made to the person who made the complaint, indicating,
i. what the licensee had done to resolve the complaint, or
ii. that the licensee believed the complaint to be unfounded and the reasons for the belief.

A. Complaint log # 031636-18, received in November 2018, identified care concerns related to care aresident #022.

i. Review of the written plan of care for resident #022 identified that the resident required assistance with care and included specific interventions for staff. Review of the physician orders revealed that in October 2018, there was a change in resident status. Interview with DOC #103 revealed that concerns were submitted to the home identifying possible harm to the resident. Furthermore, interview with RPN #134 and DOC #103 confirmed that there was no reassessment of the resident's related to concerns of potential harm.
ii. Review of the Reporting and Complaints 'Concerns and Complaint Process', revised May 2017, outlined the following procedure for concerns and complaints:
- complaint shall be investigated and resolved, were possible, and a response provided within 10 days of receiving the original complaint
- a response shall be made to the person who made the complaint
- a documented record is to be kept including all dates in which the complaint is received, action taken, and response to complainant.
iii. Review of the home's 2018 Complaints Log, did not include any documented record of the concerns received in October 2018, related to resident #022. Interview with DOC #103 confirmed that they had not included the concern in the documented log, as they felt it was resolved the same day; however, their investigation into the allegation did not include assessment of the resident and did not follow up with the complainant, as required in the home's policy.
iv. In addition, in an interview with DOC #103, they identified that, during the course of the inspection, the home had received a written complaint about the issue; which was not included in the complaint log.

2. The licensee failed to ensure that a documented record was kept in the home that included every date on which any reposnse was provided to the complainant and a description of the response.

Complaint Log #003167-18, submitted in February 2018, identified concerns

related to homes investigation into concerns.

Review of the Complaints Log from 2017 to 2018, documented the following concerns from resident #015:
i. In August 2017, concerns related to wait times for care and responsive behaviours of a co-resident
ii. In 2018, concerns related to wait times for care
iii. In 2018, Concerns related to safe feeding practices
iv In 2018, Concerns related to staff to resident interactions
v. In 2018, Concerns related to changes in dining room and recreation
Review of the Concern/Complaint Form included action taken and final resolution within 10 days; however, the record did not include the date on which any response was provided to the complainant and a description of the response.
Interview with the Administrator in December 2018, confirmed that all management staff met with resident #015 related to concerns, and responses provided to the resident were not always documented within the complaints log. (528) [s. 101. (2) (e)]

Issued on this 8 th day of April, 2019 (A1)(Appeal/Dir# DR# 115)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by Wendy Lewis (Director) - (A1) (Appeal/Dir# DR# 115)
Inspection No. / No de l'inspection :	2018_570528_0007 (A1)(Appeal/Dir# DR# 115)
Appeal/Dir# / Appel/Dir#:	DR# 115 (A1)
Log No. / No de registre :	019778-16, 033819-16, 000003-17, 000137-17, 028260-17, 001783-18, 003167-18, 031636-18, 032029-18 (A1)(Appeal/Dir# DR# 115)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Apr 08, 2019(A1)(Appeal/Dir# DR# 115)
Licensee / Titulaire de permis :	Waterdown Long Term Care Centre Inc. c/o Jarlette Health Services, 5 Beck Boulevard, PENETANGUISHENE, ON, L9M-1C1
LTC Home / Foyer de SLD :	Alexander Place 329 Parkside Drive, P.O. Box 50, Waterdown, ON, L0R-2H0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Jennifer Sipos

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 Waterdown Long Term Care Centre Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 001

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with s. 52(2) of Ontario Regulation 79/10.

Specifically, the licensee must

i. ensure that when any resident's pain is not relieved by initial interventions, the resident(s) is assessed using a clinically appropriate assessment instrument specifically designed for this purpose
ii. conduct audits, at a schedule of the home's choosing, to ensure that registered staff are assessing and treating resident's pain as outlined in the Pain Management Program
iii. keep a document record of all audits completed

Grounds / Motifs :

1. The licensee failed to ensure that when the resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A. Complaint logs # 019778-16 and 028260-17, both submitted in June 2016, identified concerns related to pain control for resident #021.

The home's 'Pain Management Program' last revised in March 2016, directed staff to screen for pain on admission. Specifically, they were to complete a comprehensive pain assessment on admission (under assessments in Point Click Care).
In addition, a comprehensive assessment was to be completed for worsening or

unrelieved pain, identified as a pain score 4/10 on verbal report, numerical or descriptive, or caregiver reported behavioural symptoms of pain.

i. Review of the plan of care for resident #021 identified that the resident had multiple diagnosis with responsive behaviours. Review of the progress notes for resident #021 identified that they had a fall in June 2016. The post fall assessment identified that the resident had a change in status, including pain, which continued after the fall. The resident was sent to hospital with injury.
ii. Review of the medical record did not include a comprehensive pain assessment when the resident was reporting ongoing pain after their fall, as confirmed in an interview with DOC #103.
iii. In addition, when the resident returned back to home with an injury, a comprehensive pain assessment was not completed, as confirmed in an interview with DOC #103. (528)

B. Complaint log # 033819-16, submitted in December 2016, identified concerns related to falls management of resident #018.

i. Documentation in the progress notes for resident #018 identified the resident was having pain on several occasions in June and July 2018.

ii. Pain was also documented in the resident's progress notes after a fall that occurred in December 2017, requiring a new order for an opioid analgesic as needed for pain. In January 2018, registered staff documented the resident displayed non verbal signs of pain, which were also reported by the SDM. Although, resident #018 had documented pain and behavioural symptoms of pain, as identified in the progress notes, a comprehensive pain assessment was not completed.

iii. During an interview with Inspector #107, registered staff #120 who routinely cared for resident #018, identified resident #018 was in pain and that a comprehensive pain assessment was not completed as they were unaware of the requirement to complete the assessment form until recently.

iv. During an interview with Inspector #107 the Director of Care (DOC) stated staff were to complete a comprehensive pain assessment when a resident had a worsening of pain or there was an increase or decrease in pain medication. The Inspector asked the DOC to review resident #018's pain assessments on Point Click

Care (PCC) and the DOC confirmed there were none available on PCC for the time period reviewed.

v. The LTC home's policy, "Resident Rights, Care and Services – Required Programs – Pain", effective date of September 2013 and revised date of March 2016, also identified that every resident with worsening pain or unrelieved pain, as identified by a pain score of 2 or 3 on RAI MDS, or a score of 4/10 on verbal self report of pain – numerical or descriptive, or care giver/family reported behavioural symptoms of pain receives a comprehensive pain assessment completed in Point Click Care.

vi. Resident #018 had documented pain and behavioural symptoms of pain greater than a four on several occasions in December 2017 and July 2018; however, a comprehensive pain assessment was not completed using a clinically appropriate assessment instrument specifically designed for pain, as required by the home's policy.

viii. Pain Screening Notes in the progress notes for resident #018 in July 2018, did not have all sections of the note completed consistently, and the resident's pain was not comprehensively assessed or screened for. Notes were missing data related to current pain management interventions, effectiveness of interventions, and evaluation and intervention initiated for pain greater than 4 or severe. Many of the notes identified the resident was demonstrating pain, however, the effectiveness of interventions section was incomplete or contradictory. The notes did not reflect an evaluation of previous interventions and the underlying causes of pain, or any interventions implemented to relieve the pain.

A comprehensive pain assessment was not completed for resident #018 using a clinically appropriate assessment instrument specifically designed for the assessment of pain when the resident had pain. (107)

C. The severity of this issue was determined to be a level 3 as there was actual harm to the resident. The scope of the issue was a level 2 as it related to two out of three residents. The home had a level 3 history as they had a related non-compliance with this section of the LTCHA that included: Voluntary Plan of Correction (VPC) issued on June 6, 2016 (2016_337581_0006) (528)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 10, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 31. (3) The staffing plan must,
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;
(b) set out the organization and scheduling of staff shifts;
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and
(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

The licensee must be compliant with s. 31(3) of Ontario Regulation 79/10.

The licensee shall prepare, submit and implement a plan to ensure the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs.

The plan must include, but is not limited, to the following:
a. steps that will be taken to ensure that the home is staffed to meet the assessed care and safety needs of all residents including consideration of the staffing complement including personal support workers and registered nurses
b. how the home will ensure the residents' needs are being met, including but not limited to, morning care, safe transferring and positioning, meal and snack service, and bathing
c. recruitment and retention of staff
d. how the home will complete audits, at a schedule of the home's choosing, to ensure that staff are following contingency plan when necessary.

Please submit the written plan, quoting log number #2018_570528_0007 and inspector Cynthia Di Tomasso by email to HamiltonSAO.moh@ontario.ca by February 25, 2019

Please ensure that the submitted written plan does not contain any PI/PHI. Check with your SAO regarding the delivery email address.

Grounds / Motifs :

1. The licensee failed to ensure that the staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs.

A. Complaint log #000137-17, submitted in January 2017, identified concerns related to staffing shortages in the home.

B. Review of the home's 2017/2018 Complaint Log, identified numerous concerns about staffing shortages effecting resident care.

C. On an identified day in November 2018, the provision of care was observed on specific home area. Although, the home area was working at their full complement

with four PSW staff and one RPN, meal service was delayed in starting.
i. Review of PSW job routines confirmed that beverage cart was to start at a specified time and meal service at a specified time.
ii. Meal service was started on the identified home area 30 minutes late. There was no reported cause of the service starting late; however, resident #028 and #029 in the dining room were visibly upset and stated that "it was talking too long", referring to meal start time, and stated that delayed start time was a regular occurrence.

D. On an identified day in November 2018, the provision of care was continuously observed on an identified home area for more than two and a half hours:
i. The daily complement for PSW staff included four PSWs on day shift; however, due to staffing shortages the home area was working with three PSW's
ii. PSW staff were observed providing continuous care to residents without any breaks.
iii. At a specified time, 12 residents were observed in bed.
iv. Resident #027 was heard calling out for help. When the LTC Inspector #528 entered the room, the resident was observed sitting in a state of undress. Interview with the resident confirmed that they had needed staff to help with activities of daily living. The resident stated they had notified staff that they needed help "about 10 minutes ago". At that time, the LTC Inspector activated the call bell to alert staff that the resident needed assistance, the call bell went unanswered. Co-residents were leaving their rooms to the dining room and were distressed seeing resident #027 in a state of undress. Approximately 30 minutes later, PSW #137 assisted resident #027 with personal care. Review of the plan of care identified that the resident required assistance of one staff for activities of daily living (ADLs). Resident #027 was not provided with the assistance to complete personal care, and after waiting for approximately 40 minutes, resident #027 was exposed to co-residents in a state of undress.
v. Interview with resident #026, who was in bed revealed they had been dressed approximately two hours prior, and had since been waiting for additional assistance. The resident stated that they had been waiting too long. The resident was assisted with personal care. Approximately 30 minutes later, resident #026 was heard calling out to staff. Interview with the resident, at that time, identified that they were required the assistance of staff. Review of the plan of care for the resident identified that they required extensive assistance of one staff member and were dependent on staff for mobility. The resident was assisted, approximately 20 minutes later, after the LTC Inspector notified staff that the resident was still waiting. Resident #026 was not

provided with assistance as required in their plan of care for personal care and mobility, in a timely manner.
vi. PSW #133 was observed walking up and down the hallways, looking for staff. Interview with PSW #133 confirmed that resident #024 had been waiting for an unidentified amount of time but they had gone in the room because the resident was distressed. In addition, PSW #133 stated that staff pressed the call bell to alert other staff that they needed assistance; however, when they were short staffed no one was around to answer the alarm and they ended up running up and down the hall looking for a second person for lifts and transfers. Review of the plan of care for resident #024 identified that they required the assistance of two staff and a mechanical lift. Resident #024 had to wait an extended period of time causing them distress.
vii. At a specified time, a call bell was ringing. PSW #118 went to the room and identified that it was PSW #133 who alerted the bell for staff assistance with a resident to complete a lift, which required two staff. PSW #118 was unable to provide the necessary assistance. PSW #133 waited an additional 15 minutes, until another staff member arrived to transfer the resident.
viii. At a specified time, only four residents were in the dining room, meal service was not started according to the homes scheduled meal times approved by the Resident Council.
ix. At a specified time, RPN #140 confirmed that resident #028 had received a medication and had not received a required intervention in a timely manner.
x. At a specified time, seven residents were in the dining room.
xi. Beverages and meal service was started on in the dining room for the identified home area approximately 30 minutes late.
xii. Three residents in the dining room, were upset that meal service was so late and stated that it has gotten worse over the last three years.
xiii. At a specified time, LTC Home Inspector #528 observed PSW #137 and #118 use a mechanical lift to get a resident out of bed. Confirmed in an interview with the Administrator, that PSW #118 was not to complete safe lifts for residents. The Administrator also confirmed that two staff were required to assist with mechanical lift to complete safe transfers of residents.
xiv. Meal service was started 40 minutes late in the identified dining room.
xv. At a specified time, resident #029 entered dining room and appeared upset. They had stated "they forgot me".
xvi. At a specified time, the hairdresser began cleaning dirty dishes from the tables. Shortly after, resident #030 stood up and stated their frustrations with the late meal service and felt rushed as they had not coffee.

xvii. PSW staff started to serve coffee and tea, approximately one hour late.
xviii. The dietary aide was observed putting food away. Observed PSW #137 tell the dietary aide that meal service was not finished.
xix. Resident #016 had not yet been fed their meal, which was placed in front of them approximately 40 minutes earlier. When the LTC Inspector asked about the resident, PSW #137 reported that they were short staffed, meal service was no longer available, and the resident would be fed an alternative instead. Review of the plan of care for the resident identified that they were a nutritional risk, were to receive nutritional supplements, and required total assistance with eating. Resident #016, who was high nutritional risk, was not provided the complete meal for breakfast or the assistance required to eat their meal.
xxi. DOC #102 and #103 were observed serving the beverage cart to residents on the identified home area. Interview with PSW #115 and PSW #117 during the course of the inspection revealed that if they were short staffed sometimes they did not have time to do the beverage/snack cart, resulting in residents not receiving snacks and beverages, as required to meet their nutritional needs. Review of job routines for PSW staff did not include beverage cart service by the Directors of Care.

E. On an identified day in November 2018, the provision of care was continuously observed on an identified home area, which was working with one PSW less than the required complement.
i. PSW #111 was observed transporting resident #030 from another home area. When they arrived on the identified home area they asked "Where is everyone?". It was at that time, DOC #102 entered the home area to implement interventions for resident #030. Interview with PSW #111 confirmed that resident #030 was found on another home area. Review of the plan of care for resident #030 identified that they were a risk for falls and directed the staff to know where the resident was at all times. Interview with RN #118 confirmed they did not know the whereabouts of resident #030, as required in their plan of care.

F. On an identified day in November 2018, review of staff complement for two home areas identified that the areas were fully staffed; however, beverage cart for meal service started 45 minutes following the scheduled start time. Multiple residents were visibly upset. Resident #028 and #029 specifically stated they were dissatisfied with the meal start time.

G. On an identified day in November 2018, the provision of care was continuously

observed on and identified home area for over two hours. The identified home area was working short one PSW staff member.
i. Thirty minutes after meal service was scheduled to start, there were no residents in the dining room. The DOC #104 was observed portering residents to the dining room.
ii. Fifteen minuted later, the Administrator entered home area and began portering residents to the dining room. The staff coordinator was observed entering dining room and started beverage cart for the identified home area, then asked staff from the neighbouring home area to come help get the residents into the dining room. One PSW from the neighbouring home area entered the identified home area to help with transfers.
iii. Meal services started on the identified home area, an hour after the scheduled start time.
There was insufficient staff on the floor to ensure residents were assisted to the dining room in a timely manner, and therefore, dining service started an hour late.

H. Review of the daily complement of PSW staff from August to November 2018 and an interview with the staffing coordinator confirmed the following:
i. In August 2018, PSW staff worked short on approximately eight occasions on day shift, three occasions on evening shift, and seven occasions on night shift.
ii. In September 2018, PSW staff worked short approximately 10 occasions on day and evening shift, and on one occasion on night shift. The schedule was not reviewed from September 23 to 29, 2018, as the home did not provide the records.
iii. In October 2018, PSW staff worked short on approximately 15 occasions on day shift and three occasions on evening shift.
iv. In November 2018, PSW staff worked short on approximately 18 occasions on day shift, one occasion on evening shift and on six occasions on night shift. Interview with the staffing coordinator confirmed that multiple staff were on modified duties or not available for scheduling.

I. Review of bathing records for residents #017, #024, and #025. The following was identified:
i. Review of the written plan of care for resident #024 identified that they required assistance with bathing. Review of Point of Care (POC) bathing records, from August to November 2018, revealed that the resident did not receive their bath on three occasions.
ii. Review of the written plan of care for resident #025 identified that they required

assistance with bathing. Review of POC bathing records, from August to November 2018, revealed that the resident did not receive their bath on three occasions.
iii. During the course of the inspection, interviews with PSW #113, #136 , #133, #137, #139 identified that the home "always" worked short and therefore bathing of residents did not get done.
iv. Interview with DOC #102 confirmed that if bathing was missed due to short staffing, extra staff would be called in the following day to make up missed baths. However, interview with PSW #138 by LTC Inspector #107, identified that the plan to call in staff was not always effective and that they had been called in that day to complete baths that had been missed due to short staffing. PSW #138 expressed concerns that they would not be able to bathe all of the scheduled residents.

J. Throughout the course of the inspection, inspectors were approached by staff on several occasions to discuss their concerns related to staffing shortages on all shifts. Interviews with PSW staff #110, #113, #114, #115, #117, #133, #136, #137, #139 and #139 all expressed concerns related to short staffing, within relation to effecting care to the residents, including bathing and wait times for assistance. Registered staff #119, #123 and #125 all expressed concerns related to the regularity in which PSW staff worked short.

K. Interview with DOC #102 revealed changes in the staffing pattern that included in October 2016, additional PSW staff were added to each shift, for dementiability and supporting the residents in the home. However, in August 2018, one full time PSW position was removed from the evening and one from the day shift; and in October 2018, a full time PSW position was removed from the nights shift. When asked why the staffing was removed permanently from the schedule, the DOC indicated that it was a budgetary decision.

L. Interview with DOC #102 identified that the home does attempt to fill vacancies in the schedule and overtime provided to staff in an effort to ensure the staffing complement is met. They did identify that they continue to work to retain staff by hosting regularly occurring staff appreciation events, take on students for early recruitment, host and attend job fairs, and are currently conducting interviews for new PSW and registered staff. (528)

M. The severity of this issue was determined to be risk of harm 2 as there was potential for harm to the residents. The scope of the issue was pattern 2. The home

had a level 2 history of non related non-compliance. (528)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 10, 2019

(A1)(Appeal/Dir# DR# 115)
The following Order(s) have been rescinded:

Order # / Ordre no : 003 **Order Type / Genre d'ordre :** Compliance Orders, s. 153. (1) (a)

Linked to Existing Order/ Lien vers ordre existant :

Pursuant to / Aux termes de :

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

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 Health and 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 Health and 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 de la Santé et 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 de la Santé et 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 8 th day of April, 2019 (A1)(Appeal/Dir# DR# 115)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by Wendy Lewis (Director) - (A1)
(Appeal/Dir# DR# 115)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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