Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jul 29, 2020	2020_595110_0009	010396-20	Complaint

Licensee/Titulaire de permis

Vigour Limited Partnership on behalf of Vigour General Partner Inc.
302 Town Centre Blvd Suite 300 MARKHAM ON L3R 0E8

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

Altamont Care Community
92 Island Road SCARBOROUGH ON M1C 2P5

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

DIANE BROWN (110), JENNIFER BATTEN (672)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): May 21, 22, 25-30, June 1-6, 8-13, 15-20 and 22-30, 2020.

The following intakes were inspected during this Complaint inspection:
Log #010396-20 - Related to a complaint from the Canadian Armed Forces regarding their observations in the home related to inadequate nutrition, skin and wound care practices, the availability of wound care supplies, frequency of resident repositioning, bathing and cleanliness of residents, staffing ratios and the use of agency staff, follow-up of incident reports, medication administration practices, the availability of food and fluids at all times, resident census/internal

transfers and bed locations, residents being bedbound for extended periods of time, supervisory oversight during all shifts, arguments with derogatory language between staff members, allegations of resident abuse, neglect and incompetent care and post mortem care.

Written Notifications, Voluntary Plans of Compliance and Compliance Orders related to LTCHA, 2007, r. 50. (2) (b) (iv) and r. 50. (2) (d), identified in this inspection have been issued in Inspection Report #2020_595110_0009, dated July 29, 2020, which was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) toured the home, reviewed health care records, observed residents and staff to resident interactions, reviewed employee training records, schedules and internal policies related to Emergency Codes, Prevention of Abuse and Neglect, Pain Management, Skin and Wound Care, Infusion Therapy, Internal Transfers and Nutrition Care and Hydration.

During the course of the inspection, the inspector(s) spoke with Acting Executive Director, Corporate Clinical Consultant, Director of Care (DOC), Associate Director of Care (ADOC), Acting Director of Care (DOC), Acting Associate Director of Care (ADOC), Resident Relations Coordinators, Nurse Practitioner (NP), RAI Coordinator, Skin and Wound Care Champion (SWCC), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), Dietary Services Manager (DSM) and dietary aides (DA), Registered Dietician (RD), Physiotherapists (PT) and physiotherapy assistants (PTAs), Director of Programs (DP) and recreational aides (RA), Office Manager (OM), Nursing/Scheduling Clerks, Environmental Support Manager (ESM) and environmental/housekeeping support staff (ESS/HSS), Physicians (MD), receptionists, Military clinical staff, Military support staff, Public Health Inspectors, Managers from the Centenary Health Services Hospital, family members, and residents.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Food Quality
Infection Prevention and Control
Medication
Nutrition and Hydration
Personal Support Services
Safe and Secure Home
Skin and Wound Care

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

- **17 WN(s)**
- **9 VPC(s)**
- **12 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

This IP was initiated In response to the Canadian Armed Forces (CAF) observation report, on an identified date, outlining a concern that only one PSW available to provide care to 40 residents.

The layout of the home was one level with four separate wings; wings 1 and 2 were known as Unit A, and wings 3 and 4 as Unit B. On an identified date an outbreak was declared throughout the home and all wings, totaling 153 residents, were placed on isolation precautions. Each of the four wings were separated by closed fire doors.

A review of the resident death register identified 49 residents passed away at Altamont Care Community over a 31day period increasing the demand on staffing to provide end of life and post mortem care. A record review of the daily staffing roster with confirmation from staffing coordinator #210 revealed daily RPN and PSW shortages, at times with only half of the staffing compliment present at the home, during the same period.

An interview with RPN #152 who worked full time and over time in the identified month, stated the staffing levels in the home were ‘horrible’. Everything was very rushed, residents exhibited behaviours, residents sustained falls, and mealtimes were very challenging. RPN #152 further indicated there were residents who were very sick, needing extra fluids for fevers, and assistance but staff had very little time to spend with them. The RPN also stated that staff were unable to provide residents continence care or assistance with repositioning as required.

RPN #152 shared that the home did not have the staff to accommodate those residents whose needs increased due to their change in health. The RPN identified resident #094 whose level of eating assistance changed when they became unwell and the home did not have the staff to support the resident. The RPN shared they would provide the resident with a supplement whenever they could but the resident lost weight because they did not have the staff to provide the level of eating assistance they required, stating the priority were those residents who needed to be fed.

The RPN revealed there were those residents who had never had a skin breakdown and acquired areas of altered skin integrity, identifying resident #016 who acquired areas of altered skin integrity because staff were unable to get the residents out of bed and reposition as required. The staff shared when the unit was short staffed, residents did not get out of bed, and resident #033 had an area of altered skin integrity that worsened. The RPN stated “I would give medications in the morning and again in the afternoon and when I went back to do their dressing they were in the same position. The staff identified that resident #079’s skin condition definitely deteriorated, stating is was related to lack of continence care and repositioning. The staff further indicated the resident became more contracted from not getting up, as the home did not have the staff.

An interview with RPN #125 who worked full time between an identified period stated that the residents who would normally be independent with feeding declined and they did not have the hands to assist them. The RPN stated they felt the residents declined quicker since they were unable to assist them with fluids and food to the degree they should have and identified resident #072 as requiring more assistance than was provided and noticed their overall intake was less. The RPN stated they would bring the resident out into the hallway so anyone passing could encourage the resident but staff were often too spread out and in rooms feeding residents.

An interview with RN #169, who worked full time shared how dramatically the home was short staffed. The RN stated that residents with an illness had no appetite. Residents needed encouragement to eat and drink but the home did not have the staff to provide the assistance. The RN revealed they had to direct staff to move on to the next resident if the resident did not want to eat as there was no time for staff to encourage a little longer, pushed a little more and offer more fluids. The focus was on the ones who were the most ill. The RN further indicated that it was not a coincidence that the residents who were still present in the home were the ones who were able to feed themselves and take their own drinks when the home did not have the staff. A review of the Weight Summary Report identified 49 residents were weighed in May 2020, and 42/49 or 86 per cent of the residents lost weight between March 2020 and May 2020.

Please refer to the following areas of non compliance identified within this report related to:
r. 50. (2) (d) Failing to provide for repositioning of resident #033. The resident experienced deterioration of a pressure ulcer resulting in significant pain.
r. 73. (1) (9) Failing to provide resident #056 the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. Resident #056 lost 8.3 kilograms of weight between two specific months. Failing to provide resident #072 mealtime assistance. The resident lost 8.4 kilograms of weight between two specific months.
r. 51. (2) (c) Failing to provide resident #003 who was unable to toilet independently some or all of the time, the assistance from staff to manage and maintain continence. The resident self restricted their fluid intake to avoid urinating in their brief as they were not provided toileting assistance. The resident was transferred to the hospital and assessed with a specified diagnosis.

The licensee failed to provide a safe environment for residents, by not providing for resident's assessed care and safety needs when the licensee failed to ensure there were

sufficient numbers of staff working in the home.

From the Daily Staffing Roster three shifts were selected and focused for review and captured as follows:

Identified shift in April 2020
A review of the staffing schedule and confirmed by staffing coordinator #210, the identified shift in April 2020 consisted of 1 RN and 3 PSWs for 133 residents. The home was short 1 RN and 1 PSW from their staffing plan.

An interview with RN #203 who worked as the only RN on the identified shift in April 2020 stated they were able to convince the prior shift RPN to stay until a specified time but felt the staffing level of 3 PSWs and 1 RN for 133 residents did not provide for a safe environment for the residents, especially after a specified time. The RN stated they were unable to monitor all residents with fevers and for respiratory distress. They were concerned about not leaving a distressed resident with another registered staff as they placed a called to the on call doctor or 911.

A record review of the home's 'Resident Death Register' identified four residents who passed away on a specified date with the specific cause of death.

There was one PSW available to provide care and safety monitoring to 44 residents the identified shift in April 2020.

The licensee has failed to provide a safe environment by not following their staffing plan with regular safety monitoring, safety checks, and medication administration as the home's staffing plan was developed to provide for a staffing mix that was consistent with residents' assessed care and safety needs.

Identified shift in April 2020
On the identified shift in April 2020, the home's census was 128 residents and the established staffing plan on a specific shift was 2 RNs, one for each unit and 4 PSWs one on each wing.

A review of the staffing schedule and as confirmed by staffing coordinator #210 on the identified shift in April 2020, consisted of 1 RN and 2 PSWs for 128 residents. The home was short 1 RN and 2 PSW from their staffing plan.

An interview with full time RN #200 who worked the identified shift in April 2020, and scheduled for the specific home area shared that when they arrived for their shift they were asked to complete a narcotic count over on another home area. The RN stated until then they were not made aware that the home was short 1 RN for a specific wing. It was after starting their shift that the RN also became aware that the home had only 2 PSWs in the home on the identified shift.

The RN stated that three residents had just passed away, the RPN on the prior shift agreed to stay overtime until a specified time, only to finish post mortem care. The RN stated that they were overwhelmed and called the on-call manager to advise of the staff shortages. The RN was requested to make staff replacement calls. The in-charge RN had the responsibility of the non-care task of calling for replacement staff. RN #200 was unable to complete this task on the identified shift in April 2020.

An interview with PSW #201 shared that they stayed in the specific wings on the above noted identified shift in April 2020 with 31 residents and their colleague looked after three other wings. The staff stated that residents on an identified wing were sick, and they tried to spend time giving them sips of fluid. The PSW shared that two residents, in particular, were at risk for falling and one resident, #175 had a fall on that specific shift. The PSW stated they were so short staffed they called 911 prior to informing the RN, as they felt the fallen resident was unwell, with a specific medical condition, not eating nor drinking, would not stay in their bed and they were unable to consistently monitor them for safety.

A record review of progress notes by RN #200 identified that resident #175 had sustained a fall at the reported time that shift. The note revealed the resident was assessed, stable, and placed into bed with multiple staff assistance. The resident was encouraged to use call bell in case of need.

An interview with RN #200 confirmed that PSW #201 had called 911, unbeknownst to them and the paramedics in turn called them to check on resident #175's status. The RN stated it was out of character for PSW #201, but they were concerned and frustrated that resident #175 had been falling the last few identified shifts and they could not consistently monitor the resident for their safety and care for all the other residents including those unwell.

An interview with PSW #202 confirmed that they were scheduled for specific wing with 27 residents on the specific shift in April 2020. However, at the beginning of their shift, RN #200 asked them to also cover other wings resulting in another 70 residents. This direction resulted in PSW #202 being responsible for the provision of care and safety monitoring of 97 residents over three home areas. The PSW stated they were originally told because of infection control reasons they were prohibited to go from one area to another, however, on the identified shift in April 2020, the home was so short staffed that RN #200 asked them to respond to any call bells, complete check and changes for continence and resident rounds for residents on three specific wings. The PSW identified that they were concerned that residents would fall while no one was present on the wings, that as soon as they heard a bell that they would run, having to change PPEs between wings, to prevent a resident from trying to self transfer when they needed toileting assistance. The PSW shared they were unable to complete safety checks and brief changes for residents on specific wings a second time during shift.

There was one PSW available to provide care and safety monitoring to 64 residents the identified shift in April 2020.

The interview with RN #200 shared that they did not feel the staffing level provided for a safe environment for residents with 2 PSWs and 1 RN being responsible for 128 residents, including monitoring those residents very ill; the building and replacements calls for specific shift sick calls. The RN and schedule identified three sick calls requiring replacement that shift. The RN further stated they could not make proper safety rounds and monitor residents closely for respiratory distress, fever or needing oxygen and that they normally do their first round at a specific time but they were dealing with the staffing shortage and calls to the on call manager they were unable to make rounds until much later.

The RN stated that they were unable to provide the regular pain assessments and 0600hrs medications to residents at a specified time.

A record review identified that resident #025 did not receive their specific medications as ordered. The order, written in capital letters, gave specific directions for a medication administration.
Resident #045 did not receive their identified assessment and resident #015 did not

receive their specific medication as ordered.

A focused review of a specific unit residents identified 12/36 residents were identified at high risk for falls on a identified shift in April 2020. The review revealed that residents were unwell; residents #092, #091 and #093 passed away on identified dates and times in April 2020.
PSW #201 interviews shared that they were split between three separate units and all residents were not monitored throughout the shift.

Identified shift in April 2020
A review of the staffing schedule and as confirmed by staffing coordinator #210 the identified shift in April 2020, consisted 8 PSWs, 1 RN, 3 RPNs instead for 128 residents. The home was short staffed by 1 RN, 2 RPNs and 8 PSW from their staffing plan.

An interview with RPN #125 revealed that when they arrived to work for their identified shift in April 2020, they were told that they were short 1 RPN and 1 RN and this would result in them being responsible to administer all medications from three medication carts on two wings for 79 residents until someone else could arrive. The RPN stated this was their first nursing job and had only worked a few casual shifts. The RPN stated that they were unable to provide resident #095 with their specifically scheduled medication order. The RPN stated it was not administered until after the resident's meal by their colleague RPN #156 who came over from another wing to help. RPN #125 stated the resident’s specific medical treatment was normally well controlled and stable, and identified another resident whose specific medical treatment were negatively affected because of the lack of regular scheduled medication administration.

A record review of the resident's, eMAR on an identified date in April 2020, indicated the medication was to be administered at a specific time with identified parameters.

The licensee failed to ensure a safe and secure environment for the residents during a specific time in April 2020. Registered staff and personal support workers were left to work with unsafe staffing levels resulting in residents not receiving basic care, medication management and treatments. [s. 5.]

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. 20. Cooling requirements

Specifically failed to comply with the following:

s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when central air conditioning was not available in the home, there was at least one separate designated cooling area available for every 40 residents.

During resident interviews conducted in June 2020 multiple residents complained to Inspector #672 that they were frustrated and uncomfortable on the wings due to feeling very hot and sweaty, as a result of the fire doors at the entrance of the wings being closed, which did not allow for air circulation, and not being allowed to open their windows or run any fans or air conditioning units. The residents indicated they were not allowed to leave the wings without being accompanied by a staff member, which could only be scheduled when a staff member was available. The residents further indicated when they were able to find a staff member available to take them off the wings, they were only allowed to leave the wing and immediately go outside onto the property and gardens but could not go anywhere else within the facility. According to the residents, this was often not a refreshing alternative to escape from the high temperatures and humidity experienced inside the wings due to the high heat and humidity outside as well.

Inspector #672 toured the home and observed that three resident wings had designated cooling stations for staff members available just outside of each wing, and one wing had a cooling station available for staff members within the wing as it had previously been a resident bedroom. Between June 16 and 30, 2020, Inspector #672 spent several hours per day on a specific in June 2020, and did not observe any residents being brought into

the cooling station on the wing to attempt to cool them down. The designated cooling stations for staff members for specific wings and Inspector #672 did not observe any residents being brought into either of the cooling stations at any time. Inspector #672 also attempted to observe the temperatures and humidex on each of the wings, but no thermometers or hygrometers were available except on one unit. On a specified date in June 2020, Inspector #672 found a thermometer on an identified unit which read 89 degrees. There was no hygrometer available to indicate the humidex reading on the unit.

During separate interviews, PSWs #108, #110, #116, #117 and #185 and RPNs #115 and #130 indicated they were not aware of any thermometers or hygrometers available on the wing to read the temperatures and humidex. PSWs #110 and #116 indicated the equipment used to be present on an identified wing but it had been missing "for a while now."

During separate interviews, PSWs #108, #110, #116, #117, #120, #121, #127, #132, #174 and #185, RPNs #115, #130 and #145 indicated residents were not allowed to leave the units at all without staff escorts, to ensure they did not wander throughout the facility and possibly spread germs to other areas. The staff further indicated that when staff members were available, a resident could request to be escorted outside for short periods of time, but they had to immediately go from the wing straight outside. PSWs #108, #110, #116, #117, #120, #121, #127, #132, #174 and #185, RPNs #115, #130 and #145 further indicated they were aware of cooling stations available in the home for staff members, as the cooling stations were being utilized as break rooms for the staff from each wing to attempt to ensure staff followed infection control prevention protocols. The staff further indicated they were not aware of cooling stations in the home available for residents to lounge in, to assist in cooling the residents and escaping the high temperatures and humidity felt on the wing. Lastly, the staff indicated no fans or air conditioning units were currently available in the home for residents to use, the wings frequently became very hot and humid throughout the day and staff were not completing any additional nourishment rounds to offer additional fluids to residents but would provide fluids to residents at any time they asked for them.

During an interview, Environmental Services Worker (ESW) #133 indicated they were aware of cooling stations available in the home for staff members, but not for the residents to utilize.

During an interview, the Corporate Clinical Consultant indicated each of the wings were

supposed to have thermometers and hygrometers available for staff to be able to read the temperatures and humidity experienced on each of the areas. The Corporate Clinical Consultant indicated the temperature on an identified wing was known to be higher than the other areas in the home due to the specific services being present on that unit, and the door to the service room should be kept closed, to assist in preventing the hot air from circulating onto the wing, but was aware that staff always had that door propped open, as the service room became too hot with keeping the door closed. The Corporate Clinical Consultant further indicated they were aware of the legislative requirements which indicated that when central air conditioning was not available in the home, there was expected to be at least one separate designated cooling area available for every 40 residents, but due to the flood on unit one and the current situation in the home, this had not been on the radar for the team to address. The Corporate Clinical Consultant indicated that staff could bring a resident into one of the designated staff cooling areas, if the staff were worried about the resident due to the temperature on the wing, but was not aware of any communication or direction which had been provided to the staff which indicated that.

The licensee failed to ensure that when central air conditioning was not available in the home due to infection control concerns, there was at least one separate designated cooling area available for every 40 residents. [s. 20. (2)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
14. Hydration status and any risks relating to hydration. O. Reg. 79/10, s. 26 (3).

s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and O. Reg. 79/10, s. 26 (4).
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3). O. Reg. 79/10, s. 26 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration.

Resident #033.

A review of resident #033's written plan of care in place on an identified date, identified the resident at moderate nutrition risk with an identified clinical risks, clinical condition, specific BMI and skin condition.

In separate interviews with registered nursing staff #114, #152 and #236 they confirmed there was no identification of a resident's identified clinical risks or clinical condition related to the hydration status on the resident's plan of care. Nursing staff identified they do not send referrals related to a resident's poor or changed fluid intake and the process to evaluate a resident's fluid intake was not in place.

An interview with the Registered Dietitian (RD) confirmed the resident's hydration was at risk related to the presence of their skin condition and that their hydration status had not been included in the plan of care. The RD further confirmed that home's corporate office, Sienna Senior Living, removed hydration status as a requirement within all resident's plan of care a few years ago when they focused on changing and simplifying the care plans. [s. 26. (3) 14.]

2. Resident #018.

Resident #018 was identified on a specific date in June 2020, with a fluid intake 50% less than their estimated fluid needs and altered skin integrity. The resident's hydration status and risks to hydration, poor intake and altered skin integrity were not identified in the resident's plan of care.

An interview with the RD confirmed that the resident's hydration status and risks to their hydration were not part of the resident's plan of care.

An interview with the DOC confirmed the home was not monitoring a resident's fluid intake and that resident care plans did not identify a resident's hydration status or risk prior to the March 2020 outbreak. [s. 26. (3) 14.]

3. Resident #062.

A review of resident #062's plan of care in place on an identified date, identified the resident at high nutritional risk and with identified risk factors placing the resident at hydration risk. The plan of care failed to include the resident's hydration status.

An interview with the RD confirmed the resident's risk factors to hydration; consistently consuming less fluid than their estimated fluid requirement; increased fluid needs for promoting healthy skin conditions, reduced accessibility of free fluids provided by a modified fluid consistency diet and requiring total staff dependence on feeding.

A record review of progress notes documented by nursing between specific dates in March and May 2020, regularly stated the resident's 'food and fluid intake is in keeping with the normal amounts of the food and fluid intake for the resident'.
The RD confirmed that hydration status and hydration risks were not part of the resident's plan of care and not the practice in the home. [s. 26. (3) 14.]

4. Resident #061

A record review identified resident #061 with had dehydration trigger during an identified assessment in April 2020, and previously during a specific date in January 2020. On both occasions the plan of care lacked an interdisciplinary assessment of the resident's hydration status.

During separate interviews both the RD and DOC confirmed the resident's plan of care was not based on the resident's hydration status and their identified risks
The RD confirmed that hydration status and risks to a resident's hydration were not identified in the resident's care plan and that it has not been the practice in the home.

The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration for all resident's in the home. [s. 26. (3) 14.]

5. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home completes a nutritional assessment whenever there was a significant change in the resident's health condition and assesses the resident's hydration status, and any related risks to their hydration.

Resident #033

A record review of resident #033's health record identified that on a specified date in January 2020, the RD responded to a dietary referral to assess the resident’s recurring skin condition. The note identified the resident consumed 10 servings of fluid, on average, per day, 125ml/serving or 1250mls. The documentation failed to include an assessment of the resident’s estimated hydration needs as compared to the resident's average fluid intake of 10 servings.

A review of the home's policy entitled 'Nutrition/Hydration Risk Identification Tool', dated March 2019, identified a resident at moderate hydration risk when they are at poor or changed fluid intake defined as less than 75% but greater than 51% of their daily fluid requirement.
Resident #033's average intake of 10 servings per day, documented on that specified date in January 2020, would be 55% (less than 75% but greater than 51%) of their daily fluid requirement of 2283mls representing a hydration risk, that had not been assessed by the RD.

An interview with the RD identified that altered skin integrity impacts a resident’s hydration needs and is a risk factor to their hydration status as adequate fluid intake plays a role in promoting healing of certain skin conditions. The RD revealed that they calculate a resident’s fluid requirement higher and higher still depending on the certain skin condition.

A further record review identified documentation on a specified date in April 2020, by the RD in response to another referral flagging resident's deteriorating skin condition. The RD's documentation identified that the resident's food and fluid intake had declined but failed to include a hydration assessment.

An interview with the RD acknowledged the lack of a hydration assessment at the specified date in April 2020 referral.

On a later specified date in April 2020, a further deterioration of the skin condition was noted and generating another dietary referral. [s. 26. (4) (a),s. 26. (4) (b)]

6. Resident #018

On May 1, 2020 the RD determined resident #018 to be at high nutritional risk related to their specific medical issue and skin conditions and low intake.
Resident #018's health record identified that the resident had a significant weight loss over a two month period.
On specified date in June 2020, a RD assessment was completed, in response to a skin impairment referral. The RD documentation identified that the resident consumed 5-8 servings of fluid or 625ml -1000ml per day. No documentation assessing the resident's fluid requirement, any shortfall in fluid intake or a hydration assessment was included

On a later specified date in June 2020 and RD assessment was complete in response to a referral that the resident's weight was below their goal weight range and decreased intake. The assessment note revealed what interventions were in place with no new approaches required.

Observations of resident #018 by Inspector #110 were conducted on specified dates in June 2020, at specific meals. The resident was not provided their level of mealtime staff assistance according to their plan of care. The resident's intake was poor.
Observations of resident #018 on another specified date in June 2020, identified their hot meal was served late, cold and the risk of influencing the desirability of the food and resident's intake.
An interview with the RD confirmed that lack of mealtime assistance, unpalatable food temperatures and skin condition were risk factors to a resident's nutrition and hydration status. The RD confirmed that these risk factors were not considered or assessed at the June 2020, referral assessments. [s. 26. (4) (a),s. 26. (4) (b)]

7. Resident #062

A record review of resident #062's health record identified a date in January 2020, where the resident was assessed and identified with altered skin integrity. The form included a check mark beside 'nutrition or hydration intervention to manage skin problems.
A review of the resident's written plan of care in place on specified date in March 2020, identified the resident at moderate nutritional risk related to an identified body mass index, specific medical issue and skin conditions The resident received a specific textured diet with modified fluid consistency and required assistance by staff with food and fluid intake.

An interview with the RD identified that altered skin integrity increases a resident's hydration needs and that adequate fluid intake played a role in the healing of skin. The RD identified that a modified fluid consistency and the resident's specific medical conditions along with a dependence on staff for eating were considered a risk factors to a resident's hydration status.

On a specified date in March 2020, resident #062's health record identified a RD assessment that included acknowledgement of resident's areas of altered skin integrity. The noted stated the resident was drinking greater than 1500mls. The note also included reference to the resident's estimated fluid needs of 2330 ml/day but there was no assessment of the resident's hydration status.

A review of the resident's fluid intake monitored in the point click care (PCC) 'Look Back Report' on specific dates between March – April 2020 identified the resident met their estimated fluid intake on 5/35 occasions.

On specified date in April 2020, the RD reassessed the resident's fluid requirement and increased the resident's requirement to 2340-2630 ml/day in response to a worsening skin conditions referral assessment . The RD identified that the resident's fluid consumption was on average 1625ml per day. A hydration assessment was not documented.

The resident's record identified the resident with a specific clinical issue on specified dates in April and May 2020, increasing the resident's need for fluids. The resident

presented with a medical condition on a specified date May 2020 and a physician note identifying the resident's deteriorating skin conditions on a specified date May 2020.

An interview with the RD acknowledged the lack of a hydration assessment on specified dates in March and April 2020, when the resident's fluid intake consistently did not meet their estimated fluid needs. . [s. 26. (4) (a),s. 26. (4) (b)]

8. Resident #097

A record review of resident #097's health record identified a hydration assessment at the time of the resident's admission on a specified date in August 2018. The assessment identified the resident required an estimated 2250mls of fluid per day.

On a specified date in December 2020, a RD note stated the resident consumed greater than 1500ml per day, with no hydration assessment or reference to their estimated fluid needs of 2250mls.
A record review of the Look Back Report for fluid intake in March 2020 - April 2020 revealed the resident seldom consumed the 2250hrs per day. From specified dates in April, 2020, the resident had an identified clinical issue that would impact the resident’s hydration needs. Between specified dates in April 2020, the resident's fluid intake was reported as 500ml -750mls per day. On a specified date in April 2020, NP #149 documented for staff to continue to monitor resident and encourage intake of fluids to prevent dehydration.

On a specified date in May 2020, the RD documented an assessment that identified the resident 'drinks fair'. The documentation failed to identify a hydration assessment or interventions to address the resident’s fair intake.

On a specified date in May 2020, the resident was identified with a specific medical issue and days later placed on specific intervention for fluid rehydration.

An interview with the RD acknowledged the lack of a hydration assessment when the resident's fluid intake was reported as greater than 1500ml per day on specified date December 2019 and when determined to be ‘fair’ on a specific date in May, 2020.

The licensee failed to ensure that the registered dietitian who is a member of the staff of the home completes an assessment of the resident's hydration status, and any risks related to hydration. [s. 26. (4) (a),s. 26. (4) (b)]

Additional Required Actions:

CO # - 003, 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 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 residents were bathed, at a minimum of twice per week, by the method of their choice.

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report, dated May 14, 2020, outlining concerns related to the personal support services for residents in the home. Specifically, the report identified that at time of arrival many of the residents had been bed bound for several weeks, with no evidence of residents being moved to wheelchair for parts of day, repositioned in bed, or washed properly. The report outlined the current staff to resident ratio at the home does not allow for more care than the most basic daily requirements that residents are changed and fed, however there was no ability to provide nail care, skin care, repositioning nor adequate wound care.

During resident interviews between specified dates in May and June 2020, Inspector #672 received complaints from multiple residents that residents were not able to shower or have a tub bath in the home, which had began at the beginning of the outbreak, around the middle of March. As a result, residents were to receive full bed-baths on their bath/shower day, but the residents indicated they had not been receiving this service a minimum of twice per week since the bathing rooms were closed to residents. The

resident complainants further indicated that when bed-baths were provided, they did not always include washing the hair, nail care or foot care.

During an interview on June 3, 2020, the Acting DOC indicated the expectation in the home was for residents to receive a bed-bath at a minimum of twice weekly, in place of the resident's regular bath/shower, as the home was not currently utilizing the bath/shower rooms, due to IPAC concerns. The Acting DOC further indicated the licensee had provided "waterless bath-in-a-bag" products for staff to utilize during the resident's bed-bath, which was to include washing the resident's hair and finger and toe nail care. Lastly, the Acting DOC indicated the licensee would begin using the shower rooms again as soon as permission was received by the Public Health Unit.

During separate interviews, residents #007, #008, #022, #032, #051, #055, #067 and #080 indicated they had complained to staff several times about their personal hygiene support and fingernail care to be lacking in the home and had requested assistance, but had not received the level of assistance required "for a long time". Several residents also indicated that prior to the pandemic, they were only ever offered the option of having a shower, despite repeated requests to have a bath instead.

During resident observations made between specified dates in May and June 2020, , Inspector #672 observed the following:

- Day 1- residents #006, #017, #018, #020, #021, #022, #062 and #072 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 2 - residents #020, #026 and #027 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 3 - residents #006, #008, #010, #014, #017, #020, #021, #022, #026, #027, #029, #030, #031, #036, #038, #051, #052, #053, #054, #055, #056, #057, #058, #059 and #060 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 4 - residents #009, #011, #012, #018, #027, #030, #062, #066, #067 and #077 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 5 - residents #009, #015, #021, #027, #030, #062 and #063 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 6 - residents #020, #022, #024, #027, #029 and #075 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 7 - residents #015, #064, #086 and #087 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 8 - residents #015, #064 and #077 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 9 - residents #015, #020, #021 and #062 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 10 - residents #062 and #077 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 11 - residents #026, #027, #044, #062, #077 and #080 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim

and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

During separate interviews, PSWs #110, #116, #117, #108, #132 and #174 indicated that they did not utilize the waterless bathing products supplied by the licensee, as they found that the products “left a greasy film” on the residents and “made the residents look and feel dirty”, which had been reported to the Acting DOC and Acting ADOC. The PSW staff further indicated that full bed-baths were supplied to the residents “depending on time” and often did not include washing the residents hair, due to the concerns with the bathing products being supplied.

On May 29, 2020, the home received an IPAC assessment completed by the Regional IPAC Specialist from Public Health Ontario, which was attended by Inspectors #110 and #672, along with the Acting DOC and Acting ADOC. During this assessment, the IPAC lead indicated it was an acceptable practice for the licensee to utilize the shower rooms for resident bathing/showers, as long as appropriate PPE was worn by staff and the rooms were cleaned after each usage.

On June 2, 2020, the Regional IPAC Specialist from Public Health Ontario provided a written report to the licensee, entitled “Post-Visit Recommendations for COVID-19 Preparedness” which indicated the following:

“6. Bathing and Hair Care: Residents are being bathed with warmed bathing wipes. Discussed that there is no restriction on bathing in tub or shower, with appropriate PPE and cleaning/disinfection between residents. There is a hair dressing salon and the sink there could be used with care to wash resident’s hair with similar cleaning protocols between residents.”

During separate interviews on June 22, 2020, residents #007, #008 and #040 indicated they still had not received any bathing/showers in the shower room and were only receiving bed-baths which did not include washing the resident’s hair.

On June 22, 2020, Inspector #672 observed the shower rooms on all units of the and observed the rooms appeared to be unsanitary, with dirt, grime and dust over the floors, tubs and equipment, with pools of stagnant water on areas of the floors and around drains. The tub on unit two was observed to be broken with yellow caution tape wrapped around it.

During separate interviews, PSWs #156, #177, #181, #190 and #191 indicated the bath tub on unit two had been broken prior to the pandemic and were unsure of when it would be fixed.

During an interview on June 22, 2020, the Corporate Clinical Consultant indicated the licensee was awaiting permission from the Centenary Health team, who was managing the home, to be able to utilize the shower rooms for resident's bath/showers. The Corporate Clinical Consultant further indicated they were aware the bath tub on unit two had been broken prior to the outbreak and the ESM was working on having it replaced. Lastly, the Corporate Clinical Consultant indicated the expectation in the home was for residents to receive a bed-bath at a minimum of twice weekly, in place of the resident's regular bath/shower.

During an interview on June 22, 2020, the ESM indicated they were aware the bath tub on unit two had been broken prior to the outbreak and was working on having it replaced "within the next two weeks".

During an interview on June 22, 2020, the Environmental Manager from the Centenary Health team (EMCH) indicated the licensee was unable to utilize the shower rooms to complete resident bath/showers due to the cleanliness of the rooms. The EMCH further indicated that the licensee had informed them that the shower rooms had been cleaned and were ready for usage, but upon inspection the rooms were not at an acceptable sanitary standard, therefore they were bringing in their own environmental service team to have the rooms cleaned over the following days.

During separate interviews in late June 2020, residents #007, #008 and #040 indicated they still had not received any bathing/showers in the shower room and were only receiving bed-baths which did not include washing the resident's hair.

During an interview on June 29, 2020, the Corporate Clinical Consultant indicated the licensee was beginning to utilize the shower rooms for resident bathing but were "taking things slowly to get the staff back into their usual routines because of all of the changes and everything that has happened. We are introducing things back one task at a time". The Corporate Clinical Consultant verified that the home was fully staffed with their regular staff members plus had additional staffing support daily through a contract with a staffing agency and also had approximately half of the usual resident census in the home.

On an identified date in June, Inspector #672 interviewed residents on each of the wings in the home and asked if the residents preferred a bath or shower; if they had informed staff of their preference or were asked what their preferences were and if they received their preferred bathing option. Residents #007, #010, #014, #024, #028, #036, #038, #040, #047, #053, #057, #064, #072, #080, #081, #082 and #083 all indicated they preferred having a tub bath instead of a shower and had informed staff of their preference but were only offered a shower or a bed bath as an option. The residents indicated they had been informed this was due to a tub not being available in the wing they resided on.

During separate interviews, PSWs #201 and #203 indicated if a resident was totally dependent for bathing assistance, they were always provided a bed bath or a shower, but never offered a tub bath as an option for the resident, as they felt the bed bath or showers were a safer option for the resident.

During separate interviews, PSWs #117, #173, #174, #190 and #200 indicated residents on unit one were only ever offered the option of a bed-bath or shower, as the wing only had a shower available and they never took residents off of the wing to provide their bathing preference. PSW #190 further indicated that they felt the bathtub available in wing two, although currently broken, was an unsafe option for residents who did not have “100% control of their entire body” due to staff having to raise residents so high in the air to get them over the lip of the bathtub, and therefore they did not use the tub when working on unit two either.

During separate interviews, PSWs #108, #120, #127 and #132 indicated residents on unit four were only ever offered the option of a shower, as the unit only had a shower available and they never took residents off of the unit to provide their bathing preference.

During separate interviews, PSWs #110, #116, #124, #135 and #202 indicated that although unit three had a bathtub available for residents, they never utilized the tub for residents to soak in the water. The PSWs indicated they would transfer the residents into the tub and then use the handheld shower to wash the residents, as there was not an actual shower stall available on the unit but filling the tub and allowing the resident to soak in the water “took too much time”.

During separate interviews, PSWs #109, #204 and #216 indicated they would ask the residents whether they preferred a bath or shower and would then take the resident to

whichever unit had the amenities available to meet the resident's preference.

During separate interviews, the Acting DOC, Acting ADOC, DOC, ADOC #137 and the Corporate Clinical Consultant indicated the expectation in the home was for residents to be provided a full bed-bath at a minimum of twice weekly on the resident's bath/shower day, which was to include all personal hygiene services, including washing the resident's hair and nail care. The DOC, ADOC #137 and the Corporate Clinical Consultant further indicated the expectation in the home was for residents to be asked what their bathing preferences were in relation to having a bath or a shower and to be taken to another wing, if need be, in order to meet the resident's needs and/or preferences.

The licensee failed to ensure that residents were bathed, at a minimum of twice per week, by the method of their choice. [s. 33. (1)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with 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 has failed to ensure that staff in the long term care home participated in the implementation of the infection prevention and control program.

This Inspection Protocol (IP) was initiated based on the CAF's observation report, dated May 14, 2020, of standards of practice issues and poor infection prevention and control (IPAC).

Inspector #672 made the following observations related to infection prevention and control practices in the home between May 21 and June 30, 2020:

Related to hand hygiene:

• Between May 21 and June 11, 2020, multiple staff members were observed to be pushing resident's wheelchairs in hallways while wearing PPE which included gowns and gloves, but did not change their PPE or complete hand hygiene after they assisted the residents.

• Between June 11 and 30, 2020, multiple staff members were observed to assist residents with personal and/or continence care and were not observed to complete hand hygiene following the resident assistance.

• Between May 21 and June 11, 2020, there were multiple incidents observed of staff members assisting an unwell resident or interacting with an unwell resident's environment without changing PPE or conducting hand hygiene and then go on to assist another resident.

• Between May 21 and June 21, 2020, there were multiple observed incidents of staff members using hand sanitizer on gloves, instead of changing the gloves and/or performing hand hygiene.

• Between May 21 and June 30, 2020, Inspector #672 observed parts of several medication administration passes and did not observe hand hygiene being completed between residents, when staff were observed assisting the resident in some way i.e. taking the cup of water back from the resident or administering puffers or eye drops.

• Between May 21 and June 30, 2020, Inspector #672 observed multiple nourishment services in the mornings and/or afternoons and did not observe hand hygiene being offered or provided to residents prior to ingesting morning/afternoon nourishment.

• Between May 21 and June 30, 2020, Inspector #672 observed multiple meal services for both lunch and dinner meals and did not observe hand hygiene being offered or provided to residents prior to ingesting meals.

Related to Personal Protective Equipment (PPE):

• Between May 21 and June 11, 2020, there were multiple incidents of PPE not being readily available close to both unwell and not sick resident's bedrooms, for staff to utilize.

• Between May 21 and June 11, 2020, multiple staff members were observed to be assisting residents with personal and/or continence care while wearing PPE which included gowns and gloves and were not observed to change their PPE after they assisted the residents.

• Between May 21 and June 11, 2020, there were multiple incidents of staff members not donning/doffing PPE appropriately, or disposing of the PPE properly.

• Between May 21 and June 11, 2020, there were multiple incidents when staff members were observed not wearing PPE appropriately, such as wearing multiple masks at the same time or having several pairs of gloves on.

• Between May 21 and June 30, 2020, there were multiple incidents when environmental staff members were observed to be interacting with both unwell and not sick resident's environments without changing PPE and/or conducting hand hygiene between each resident/resident's environment.

• Between May 21 and June 5, 2020, there were multiple observed incidents of staff members outside of the home on the grounds and parking lot, in full PPE which included gowns and gloves, and then entering the home without changing the PPE. While the staff were outside on breaks, there was no physical distancing observed and staff would often be observed standing in small groups interacting or watching something on a telephone screen.

Related to Physical Distancing:

• Between May 21 and June 11, 2020, both unwell and well residents were observed to be cohorted together in the same bedrooms, while there were empty bedrooms available within other unoccupied resident home areas within the home.

• Between May 21 and June 30, 2020, staff were not observed implementing physical distancing practices on the resident home areas, for any of the residents. Residents were found congregating in groups at the end of the hallways, looking out the windows or watching the television.

• Between May 21 and 28, 2020, there were several incidents of staff being observed sitting on unwell resident's beds or in their wheelchairs while assisting the resident with

food/fluid intake.

During separate interviews, PSWs #101, #106, #107, #127 and #132 indicated they utilized hand sanitizer on gloves during nourishment service and following assisting residents with personal care instead of changing gloves between assisting residents, as they felt it would utilize “too many gloves” if they changed them every time and/or assisted in saving time.

During separate interviews, PSWs #101, #106, #108, #127, #146, #171, #174, #188, ESA #133, RPN #130 and PTA #102 indicated they preferred to wear double masks, multiple pairs of gloves or several gowns at a time as it made them “feel more comfortable”, “feel safer” or “help save time”. PSWs #101, #106, #108, #127, #146, #171, #188, ESA #133, RPN #130 and PTA #102 further indicated they had received education and training related to the proper usage of PPE in the home.

During separate interviews, PSWs #108, #109, #110, #116, #117, #120, #121, #124, #127, #131, #132, #135, #139, #173, #174, #176, #177, #178, #181, #182, #191, #192, #200, #203, #204, #214, #216, #231, ESAs #133 and #207 and PTA #102 indicated the expectation in the home was for PPE to be changed between assisting each resident with personal care and hand hygiene was to be completed prior to and following assisting a resident with eating, at the beginning and end of each nourishment pass, after assisting a resident with personal care and after interacting with a resident’s environment or belongings, such as pushing a wheelchair.

During separate interviews, PSWs #101, #108, #109, #110, #116, #117, #120, #121, #174 and #200 indicated the expectation in the home was for residents to receive hand hygiene prior to ingesting each meal or nourishment.

During separate interviews, PSWs #185, #191, #202, #213, #214 and #224 indicated residents did not require hand hygiene to be performed prior to ingesting each meal or nourishment, as “the resident should have received hand hygiene during personal care” and “residents don’t go anywhere to get dirty”.

During separate interviews, PSWs #101, #108, #109, #110, #116, #117, #120, #121, #131, #174 and #200 indicated the expectation in the home was for physical distancing between residents to be maintained, but “it was too hard” to ensure residents maintained physical distancing in the home, related to limited spaces for the residents to congregate on the resident wings and some residents experiencing responsive behaviours and/or

dementia.

During separate interviews, PSWs #124, #132, #135, #146, #171, #173, #176, #177, #181, #185, #188, #191, #192 and #213 indicated the expectation in the home related to physical distancing between residents was that residents were to be kept on their resident wing to prevent interaction between the units in the home, but if the resident remained on the wing, they could congregate wherever they liked.

During separate interviews, RPNs #114, #115, #130, #145, #212 and RN #215 indicated the expectation in the home was for hand hygiene to be completed prior to and following administering medications to each resident, if they touched or assisted the resident or the resident's environment in any way.

During an interview, the Acting ADOC indicated the expectation in the home was for unwell and well residents to be cohorted in separate bedrooms. The Acting ADOC further indicated the expectation in the home related to hand hygiene was for staff to perform hand hygiene and/or change PPE after every physical interaction with a resident or the resident's environment and hand hygiene was to be completed for every resident prior to consuming any food/fluids. Lastly, the Acting ADOC indicated it was never an accepted practice in the home to use hand sanitizer on a pair of gloves instead of performing hand hygiene or changing the gloves; to not wear PPE as directed, which included wearing multiple sets of PPE; and all staff members had received education regarding how to properly don/doff PPE.

During separate interviews, the Acting DOC, Corporate Clinical Consultant and ADOC #137 indicated the expectation in the home related to hand hygiene was for staff to perform hand hygiene and/or change PPE after every physical interaction with a resident or the resident's environment, which included during medication administration, and hand hygiene was to be completed for every resident prior to consuming any food/fluids. The Acting DOC, Corporate Clinical Consultant and ADOC #137 further indicated the expectation in the home was for physical distancing between residents to be maintained, where possible, both on and off the wings. Lastly, the Acting DOC, Corporate Clinical Consultant and ADOC #137 indicated it was never an accepted practice in the home to use hand sanitizer on a pair of gloves instead of performing hand hygiene or changing the gloves; to not wear PPE as directed, which included wearing multiple sets of PPE; and all staff members had received education regarding how to properly don/doff PPE.

The licensee failed to ensure that staff participated in the implementation of the infection

prevention and control program during the pandemic between May 21 and June 30, 2020 when the Inspector was on-site. [s. 229. (4)]

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with 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:
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences. O. Reg. 79/10, s. 73 (1).**

**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:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).**

**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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).**

**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:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. 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 has failed to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On March 31, 2020, the home was placed on isolation precaution, dining room service was suspended and tray service began.

From March 31, 2020 until May 18, 2020 tray service was accompanied to the wings with

a resident diet sheet referencing the resident's name, room number, diet, diet texture and fluid consistency. The system failed to include resident's special needs and preferences.

A record review of resident #003s health record identified a note by nurse practitioner #149 on an identified date, that the resident had a change in condition and for staff to encourage fluid intake. The resident's RD admission assessment documented the resident's fluid preferences.

During separate interview with PSW #127, PSW #235 and PSW #108 the resident's fluid preferences were inconsistent and not in keeping with the RD's documentation.

An interview with resident #063 and #051 separately identified they loved milk but were not receiving it at meals and snacks.

An interview with an agency PSW #232 shared there was no process in place to guide agency staff in offering residents their preferred fluids and a staff would not know who preferred milk or their preferences. The PSW shared there was only a resident list with the resident's name, room number, diet, diet texture and fluid consistency.

An interview with dietary aide's #239 and #238 confirmed a system was not in place to ensure dietary staff portioning residents food on tray service were aware of resident's special needs and preferences. The staff shared that military staff would come into the kitchen and ask staff if a resident could have milk and also gave dietary staff a list of residents who did not like eggs.

Dietary aide #239 shared that resident #087 will not eat anything with gravy. Dietary aide #238 confirmed that as a food service workers plating resident #087's meal they would not be aware of their preference for 'no gravy' when preparing their meal tray.

A record review of resident #024's health record identified the resident required for straw for all fluids.

Dietary aide's #239 and #238 expressed an unawareness of the resident's need for straws for when setting up the resident's meal tray. They confirmed there was no process in place to ensure that food service workers and other staff assisting residents were aware of the resident #024 need for straws.

An interview with military personnel identified there was no system in place at mealtimes

to identify resident's dietary special needs and preferences. An interview with PSW #101 confirmed same.

The resident's continued on tray service until at least June 30, 2020, when Inspectors left the home, representing a three month period of time.

An interview with RD #217 confirmed a process was not in place to communicate to PSW staff, assisting residents on the wings, a resident's preferences. [s. 73. (1) 5.]

2. The licensee has failed to ensure that food and fluids served at a temperature that is both safe and palatable to the residents.

The home is a 4 wing design accommodating 158 residents.

On March 25, 2020 wing 3 went on isolation precautions and 29 residents began meal service on trays. On March 31, 2020, the remaining residents in the home, wings 1, 2 and 3 went on isolation precautions and also began tray service.

Staff interviews identified the following practice had been in place with respect to tray service.

Food was served on disposable plates covered with saran for approximately 6 weeks then cardboard folding takeout containers for 4 weeks. There was no thermal system in place to keep hot food hot.

Inspectors #672 and #110 arrived on site in the home on May 21, 2020.

During the course of the inspection the following interviews and observations were conducted with respect to the temperature palatability of the food:

May 22, 2020 - Inspector #672
Resident #032 complained their hot meal was served to them cold. Residents #007, #008, #040, #039 all indicated their meals were served cold therefore they didn't enjoy/eat the entire meal. Resident #022 indicated the meal "could have been warmer, but it wasn't terrible".

June 13, 2020 - Inspector #672
Residents #038, #032, #039 and #040 indicated the soup and the meat were too cold

and couldn't be finished.Resident #042 stated the soup was too cold to enjoy/eat.
Resident #043 stated the soup and meat were too cold and did not eat the meal. The resident declined the Inspectors offer to have the meal reheated, stating they had "lost their appetite".
Resident #045 – stated the meat and soup were too cold to eat, and left the tray untouched. the resident also declined the Inspectors offer to have food reheated.
Resident #046 – Stated they could not eat the meat and soup as it was too cold. Inspector requested a bowl of soup be reheated for resident. Soup reheated and the resident ate the entire serving.

June 16, 2020 -Inspector #672
Resident #052 was observed still eating their eating lunch at 1350hr and stated it was difficult to eat because it was not palatable due to being served cold.

June 17, 2020 - Inspector #672
Resident's #065 - stated the chicken fingers were served cold and resident #027 stated they were served cold and therefore did not eat their entire meal. Resident's #068, #069 and #070 further indicated their lunch meal had been served cold, which they did not enjoy. Resident #045 stated "well, it should have been warm but it wasn't. I wasn't too hungry anyway, so I guess it didn't matter."

June 18, 2020 Inspector #110 entered wing 3 at 1200hrs. At 1215hr an upright cart of meal trays covered in plastic arrived onto the wing. At 1258hrs resident #018 was served their meal. Resident #018 was severely cognitively impaired and unable to express the temperature palatability of their meal.

At 1258hrs the pureed food was congealed in appearance with no presence of steam.

Food temperatures were taken and probed as follows at the time the resident was served as follows:
Pureed meat - 86 degree F
Pureed vegetables -85 degree F
mashed potatoes - 101 degree F
Soup -130 degree F
The reading from the temperature probe were confirmed by PSW #192.

June 20, 2020 - Inspector #110

Resident #063 shared that the lunch meal 'wasn't really hot enough'.

The residents remained on tray service until the last day the Inspectors were on-site or June 30, 2020.

An interview with the Director of Dietary Services confirmed that the home’s policy required hot food to be served at the point of service greater than or equal to 140 degree Fahrenheit. [s. 73. (1) 6.]

3. The licensee has failed to ensure that the resident is provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report, dated May 14, 2020, reporting inadequate nutrition of residents due to underfeeding.

During the inspection period staff interviews revealed how tray service placed added demands on staff to provide total feeding assistance to those residents requiring it and encouragement to others, especially when short staffed. The Director of Dietary Services identified how the dining room service allowed for groupings of 4 residents to 1 PSW per table; two residents being provided total feeding assistance while two residents are provided with the necessary encouragement and prompting while tray service to each resident does not provide for staffing efficiency.

Resident #072

An interview with RPN #125 who worked full time on wing 3 over an identified 20 day period stated that some residents who would normally be independent with feeding declined and they did have the hands to assist them. The RPN stated they felt the residents declined quicker since they were unable to assist them with fluids and food to the degree they should have and identified resident #072 as requiring more eating assistance than was provided and noticed their overall intake was less. The RPN stated they would bring the resident out into the hallway so anyone passing could encourage the resident but staff were often too spread out and in rooms assisting other residents.

Resident #072's plan of care identified their level of mealtime assistance over this identified 20 day period.

Interviews with PSW #122 stated there were usually 3 PSWs instead of 4 and that 9-11 residents required feeding assistance and four required encouragement and prompting at mealtimes. The PSW stated that resident #072 required an identified level of assistance but the priority was given to those resident's who required total feeding assistance. PSW #204 confirmed resident #072's need for mealtime assistance, stating the resident sometimes required even more staff assistance at mealtimes.

A record review of the staffing schedule identified resident's wing often had 3 instead of 4 PSWs on days (covering breakfast and lunch) and 2 instead of 4 PSW on afternoons (covering dinner) over an identified period of time.

A record review of the Weight Summary Report identified that resident #072 lost significant weight over the same identified two and one half month period.

A further record review identified that at the end of the two and one half month period the resident's plan of care for mealtime assistance was changed to require additional mealtime assistance. [s. 73. (1) 9.]

4. Resident #018

Resident #018 resided on wing 3 until an identified time at which time they were moved to wing 2.

Interviews with PSWs #122 and #204 from wing 3 identified resident #018's level of mealtime assistance prior to the resident's move to wing 2.

A review of the resident's written plan of care identified their level of dependence on staff for mealtimes.

Meal observations of resident #018 were completed as follows:

On an identified date- by Inspector #672
1216hrs- resident's lunch tray of pureed chicken, mashed potatoes and carrots was served and set up for resident.
1231hrs- resident had not eaten and unassisted by staff. Inspector #672 inquired with staff and was informed that the resident's level of mealtime assistance stated was not the level identified in the resident's plan of care.

1250hrs -PSW #181 assisted the resident with their meal but not drinks. No fluids were offered or taken by the resident.

On a second identified time - by Inspector #110
1740hrs resident was served their meal tray and set up.
1800hrs resident had not eaten and was unassisted by staff. Inspector approached RPN #230.

On a third identified date - by Inspectors #110 and #672.
1258hrs resident was served their meal tray late and set up. Trays arrived to the unit at 1215hrs. Temperatures of hot food were taken when served to the resident and cold. PSW #192 set up the resident's meal tray and reported to Inspectors that the resident was independent in eating. PSW #192 returned to the resident at 1311hrs.

A record review of the resident's Weight Summary Report identified the resident lost significant weight over an identified two and one half time period. [s. 73. (1) 9.]

5. Resident #015

Resident #015's plan of care identified their level of feeding assistance.

Interviews with PSW #213 and RPN #152 confirmed awareness of the resident's level of assistance.

A review of the progress notes identified on an identified date the resident had a change of condition but not showing signs and symptoms. A progress note a few weeks later revealed the resident's condition was resolved.

An interview with PSW #211 identified they worked 25 evening shifts on resident #015's wing over an identified period of time. The PSW reported they often worked short with only 2 PSWs for 35-24 residents and on two occasions worked alone. The PSW shared at dinner they would serve everyone their meal tray then go back to provided total feeding assistance to those residents requiring to be fed. The PSW shared they were unable to provide residents including resident #015 with the level of mealtime assistance they required. The PSW shared that when residents were unwell and dying you also wanted to spend time with them but they did not have sufficient time for everything.

A record review of the 'Weight Summary Report' identified that resident #015 lost

significant weight over an identified two and one half month period of time.

Interviews with RPNs #152, #156 and #125 all identified that when staffing levels were short residents requiring total assistance with eating were the priorities while those resident's requiring encouragement and supervision were not supported at meals in the manner they required.

A further review of resident's #015's plan of care identified an update on June 5, 2020 to their level of feeding assistance requiring further staff assistance at mealtimes.

On an identified date the following meal observation of resident #015 was conducted by Inspector #672 .
1232hrs lunch meal tray was served while resident was sitting in bed. Staff indicated resident was independent with meals. The tray was not set up.
1243hrs RPN went in to administer resident’s medications and was not observed to set-up or encourage the resident with their meal; the resident had not as yet eaten.
1250hrs resident’s meal container remained unopened.
1259hrs PSW #181 entered resident’s room and asked the resident if they were finished with their lunch while removing the meal tray.

The resident was not provided with the level of mealtime assistance they required. [s. 73. (1) 9.]

6. Resident #009

During a record review, resident #009 was noted to be at high nutritional risk with identified circumstances and at high risk for heat, therefore required fluids to be encouraged. The resident was dependent on staff with meals and fluid intake.

During resident observations over a 10 day period, Inspector #672 observed that resident #009 was served food and/or fluids on six separate occasions, without the level of mealtime assistance being provided to the resident to ingest them.

During separate interviews, PSWs #101, #127 and #132 verified that resident #009 was dependent on staff assistance at mealtimes to ingest food and/or fluids, and the expectation in the home was for each resident to receive the level of assistance they required.

Resident #020

During a record review, resident #020 was noted to be at high nutritional risk with identified circumstances and at high risk for heat related illness, therefore required fluids to be encouraged. The resident required staff assistance with meals and fluid intake.

During observations of resident #020 over a 25 day period, Inspector #672 observed that resident #020 was served food and/or fluids on nine separate occasions, without the required level of mealtime assistance being provided to the resident to ingest them.

During separate interviews, PSWs #108, #132 and #216 verified that resident #020 was dependent on staff assistance at mealtimes to ingest food and/or fluids, and the expectation in the home was for each resident to receive the level of assistance they required.

Resident #029

During record review, resident #029 was noted to be at moderate nutritional risk with identified circumstances and at high risk for heat related illness, therefore required fluids to be offered and encouraged. The resident was dependent on staff with meals and fluid intake.

During observations of resident #029 over a nine day period, Inspector #672 observed that resident #029 was served food and/or fluids on four separate occasions, without the required level of staff assistance being provided to the resident to ingest them.

During separate interviews, PSWs #101, #127 and #132 verified that resident #029 was dependent on staff assistance at mealtimes to ingest food and/or fluids, and the expectation in the home was for each resident to receive the level of assistance they required.

Further resident observations made over a five week period, Inspector #672 identified residents #006, #011, #012, #013, #014, #015, #016, #018, #019, #021, #026, #030, #037, #048, #063, #072 and #080 were served food and/or fluids without the required level of staff assistance being provided to the resident to ingest them.

During separate interviews, RPNs #130 and #145 and RNs #129 and #215 verified that residents #009, #020 and #029 required staff assistance to ingest food and/or fluids and

the expectation in the home was that staff provide the level of assistance required by each resident to ensure optimal intake of both food and fluids. [s. 73. (1) 9.]

7. Resident #056

An interview with PSW #116 who worked full time in an identified month shared that staffing was dramatically impacted as the wing normally had four PSWs on days and staffing went to three and sometime two PSWs for 37 residents in the beginning. The PSW stated that resident #056 needed more assistance at meals but they did not have the time to spend with them and that the resident lost weight.

An interview with RPN #152 who also worked full time over an identified period stated that the time in question was “horrible” for staffing and the priority went to those residents who required feeding. The RPN isolated resident #056 as a resident who required more assistance than they were able to provide and as a consequence the resident lost weight. They continued to say that whenever they could they would provide the resident a nutritional supplement and that they were one of the residents who needs increased and they could not accommodate for them.

A record review identified the resident's plan of care for eating changed after the short staffing period to requiring more staff assistance at mealtimes.

A record of the Weight Summary Report identified resident #056 had lost significant weight over a two and one half month period.

Additional observations:

On an identified date, Inspector #672 observed that residents #009 and #020 were sent labelled specialty drinks from the kitchen at the afternoon nourishment pass. Inspector #672 observed the drinks being delivered to the resident’s bedroom, but no assistance was provided to either resident to ingest the drink as needed. During observations on another date, Inspector #672 observed resident #029 had a drink delivered to a table in their bedroom, but resident #029 was sitting in another area of their room and unable to access or reach the drink. No staff member returned to provide any assistance to resident #029 for them to ingest their drink as needed.

On an identified date, Inspector #672 observed the morning and afternoon nourishment passes along with lunch meal service. Observations included multiple residents,

including residents #009, #020, and #029, not being offered assistance with ingesting food and/or fluids during the nourishment passes or during meal service as needed.

During separate interviews, the Acting DOC, DOC, Corporate Clinical Consultant and DDS indicated the expectation in the home was that staff provide the level of assistance required by each resident during nourishment and meal services to ensure the optimal intake of both food and fluids.

The licensee failed to ensure that multiple residents in the home, including residents, #072, #018, #015, #056, #030. #009, #020 and #029 were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. [s. 73. (1) 9.]

8. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

During resident mealtime observations over a five week period, Inspector #672 observed multiple PSWs feeding residents food and/or drinks without using proper techniques or the safe positioning of residents including residents #009, #020, #030.

Resident #009:

During a record review, resident #009 was noted to be at high nutritional risk for identified reasons including having swallowing difficulties.

During a resident observation on an identified date, at 1500hrs, Inspector #672 observed PSW #101 assist the resident with a drink and noted the PSW attempted to provide the resident their drink without raising the head of the bed (HOB) and the resident was laying flat. Resident #009 was immediately observed to cough on two occasions, therefore the PSW stopped assisting the resident and the drink was not ingested.

During separate interviews, PSWs #101 and #127 indicated they did not position resident #009 in a seated position during ingestion of meals/fluids due to the resident experiencing increased pain when in an upright, seated position.

Further observations of resident #009 by Inspector #672 identified the resident being assisted with meals and/or fluids on six separate occasions without the use of proper techniques, which included safe positioning.

Resident #020:

During record review, resident #020 was noted to be at high nutritional risk for identified reasons including having swallowing difficulties.

A resident observation, on an identified date at lunch, revealed PSW #108 assisting resident #020 with their meal while the resident was positioned in bed in an almost flat position; the HOB was barely raised.

Further observations by Inspector #672 of resident #020 revealed the resident being assisted with meals and/or fluids on four separate occasions without the use of proper techniques, which included safe positioning.

Resident #030:

During a record review, resident #030 was noted to be at high nutritional risk for identified reasons including having swallowing difficulties.

Further observations of resident #030 revealed the resident being assisted with meals and/or fluids on three separate occasions without the use of proper techniques, which included safe positioning.

Additional resident observations over a five week period by Inspector #672 revealed residents #007, #021, #025, #041, #050, #064, #068, #071 and #072 struggling to ingest food and/or fluids, as proper techniques including safe positioning, were not implemented on multiple occasions.

During separate interviews, RPNs #125 and #172 stated the expectation in the home was that when residents were eating or drinking, they should be in a high Fowler’s position.

During separate interviews, the Acting DOC, DOC, Corporate Clinical Consultant and DDS indicated the expectation in the home was that staff provide safe positioning and proper feeding techniques every time a resident is assisted with food and/or fluid intake.

The licensee failed to ensure that multiple residents in the home, including residents #009, #020 and #030 were provided with safe positioning and proper feeding techniques

every time the residents were eating and/or assisted with food or fluid intake. [s. 73. (1) 10.]

9. 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.

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report, dated May 14, 2020, reporting inadequate nutrition due to underfeeding.

Over a five week period, Inspector #672 observed multiple incidents of PSWs serving residents including resident #009, #011, #020 and #029 their meal trays, snacks and/or fluids before a staff member was available to assist the resident with their nutritional intake.

Related to resident #009:

During a record review, resident #009 was noted to be at high nutritional risk and required an identified level of staff assistance with their food/fluid intake.

During a resident observation on an identified date, resident #009 was observed to have their afternoon nourishment served to them at 1500 hours, without a staff member being available to assist the resident.

Further observations of resident #009 revealed the resident being served meals and/or fluids on six separate occasions without a staff member being available to assist the resident with their intake.On a separate occasion resident #009 was observed to have their lunch meal tray delivered to their room at 1214 hours. The meal tray was placed on the dresser beside the resident’s bed and lids removed, but staff were not present in the room to assist the resident to consume their meal. At 1236 hours, staff were still not present to assist the resident with their meal and resident #009 was observed to be asleep in bed. Inspector #672 approached RPN #130 and asked if there was a staff member assigned to assist the resident. RPN #130 indicated a PSW would be in as soon as possible to assist the resident, as they were all busy assisting other residents with their meals. PSW #127 arrived at 1242 hours to assist resident #009 with their lunch meal. The tray was removed at 1257 hours and PSW #127 indicated the resident did not wish to eat any more. Inspector #672 reviewed the resident’s meal tray, and it appeared that the resident had only eaten a few bites of their meal and the cups

appeared to remain full.

During a record review, Inspector #672 noted resident #009 lost significant weight over a two and a half month period.

Related to resident #011

During record review, resident #011 was noted to be at high nutritional risk and required an identified level of staff assistance with their food/fluid intake.

Observations of resident #011 over a three week period, revealed the resident being served meals and/or fluids on four separate occasions without a staff member being available to assist the resident with their intake.

During an observation of resident #011 on an identified date, Inspector #672 observed the resident was served their lunch meal at 1212 hours, with no staff members present to assist the resident with their meal. At 1236 hours, the meal tray was still sitting opened in place, therefore Inspector #672 asked RPN #152 if a staff member was assigned to assist the resident. RPN #152 asked PSW #186 to assist the resident with the meal at 1242 hours. Inspector #672 returned to check on resident #011 at 1300, 1315 and 1325 hours and observed that three drinks served with the meal still had their lids closed and did not appear to have been touched. The lunch tray was removed from resident #011's room at 1325 hours. Inspector #672 then picked up each of the three cups and noted each felt completely full. A review of resident #011's meal intake documentation indicated the PSW did not document the resident's intake at this identified meal.

A record review of the Weight Summary Report identified the resident lost weight over a four month period.

Related to resident #020:

During record review, resident #020 was noted to be at high nutritional risk and required an identified level of staff assistance with their food/fluid intake.

During an observation of resident #020 on an identified date, Inspector #672 observed resident #020 had the lunch meal tray delivered to them at 1245 hours. The meal tray was placed opened on the resident's bedside table, but staff were not present in the room to assist the resident consume their meal. At 1308 hours, there were still no staff

available to assist the resident. Inspector #672 approached RPN #130 and asked if there was a staff member assigned to assist resident #020 with their meal. RPN #130 indicated a PSW would be in as soon as possible to assist the resident, as they were all busy assisting other residents with their meals. At 1318 hrs, staff were still not present to assist the resident with their meal, therefore Inspector #672 reapproached RPN #130 and asked if there was a staff member assigned to assist the resident. RPN #130 directed PSW #108 to assist resident #020 with their meal at that time. At 1321 hours, PSW #108 exited resident #020's room and indicated to RPN #130 that the resident had finished their meal. As less than four minutes had passed, Inspector #672 entered resident #020's room, inspected the meal tray and observed that all of the lids on resident #020's cups remained closed and the cups were full, it appeared that 100% of the meal was still present and the dessert pudding cup remained unopened. The Inspector reported the findings to RPN #130, who did not follow up with PSW #108, therefore Inspector reported the findings to the Acting Executive Director and the Corporate Clinical Consultant. The Corporate Clinical Consultant indicated they would follow up with the staff member.

Observations of resident #020 over a four week time period revealed the resident being served meals and/or fluids on ten other occasions without a staff member being available to assist the resident with their intake.

A record review of the Weight Summary Report revealed the resident lost significant weight over a four month period.

Related to resident #029:

During record review, resident #029 was noted to be at moderate nutritional risk and required an identified level of staff assistance with their food/fluid intake.

During an observation of resident #029 on an identified date, Inspector #672 observed resident #029 had their lunch meal tray delivered at 1235 hours. The meal tray was placed opened on the resident's overbed table, but no staff were present in the room to assist the resident consume their meal. At 1300 hours, there were still no staff available to assist the resident #029 with their meal and the resident presented as very agitated, calling out and pointing to their meal tray, which was out of reach of the resident. Inspector #672 attempted to explain to resident #029 that a staff member would be there shortly to assist with the meal, but the resident continued to be agitated, therefore Inspector #672 approached RPN #130 and asked if there was a staff member assigned

to assist the resident. RPN #130 directed PSW #127 to assist resident #029 with their meal and they arrived to assist resident #029 at 1317 hours. Resident #029 was noted to de-escalate immediately once they began eating their meal.

Further observations of resident #029 over a four week period, revealed the resident being served meals and/or fluids on five other occasions without a staff member being available to assist the resident with their intake.

A record review of the Weight Summary Report identified the resident had lost weight over an identified three month period.

Additional resident observations during the inspection period , revealed 22 residents being served food and/or fluids prior to a staff member being available to assist the resident.

During separate interviews, PSWs #108, #127, #181, #185 and #186 indicated the expectation in the home was for food and/or fluids to be served to a resident who required assistance only when there was a staff member available to assist the resident. PSWs #108, #127, #181, #185 and #186 further indicated meals or nourishment were being served to residents prior to staff being available to assist due to there being more residents on each wing who required assistance with their meal than staff members who were available to assist them.

During separate interviews, the Acting DOC, DOC, DDS and the Corporate Clinical Consultant indicated the expectation in the home was for meal trays and/or nourishment were to be served to a resident only when there was a staff member available to assist the resident, according to the resident’s planned care needs.

The licensee failed to ensure that multiple residents in the home, including residents #009, #011, #020 and #029, who required assistance with eating or drinking, were not served food or fluids until someone was available to provide the assistance required by the resident. [s. 73. (2) (b)]

Additional Required Actions:

CO # - 006, 010, 011, 012 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

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

Related to Log #010420-20:

During separate interviews, RPNs #130, #145, #148 #152 and #212 along with PSWs #101, #108, #117 and #120 indicated resident #009 was at high risk for altered skin integrity and required identified scheduled care of a resident in order to protect their skin and prevent further changes of altered skin integrity from occurring.

During record review, Inspector #672 reviewed resident #009's skin and wound assessments and observed that on specific date May 2020, resident #009 had a skin condition noted to an identified area. On a later specific date in May 2020, resident #009 was noted to have a second skin condition. Resident #009 was also noted to have another identified skin condition area, with a worsening condition requiring a medication order to be initiated.

During separate interviews, the Acting DOC, Corporate Clinical Consultant and the Wound Care Champion indicated the expectation in the home was that every skin condition should be assessed and documented on, on a weekly basis and the registered staff had received education regarding when and how to complete the weekly wound assessments.

During review of the weekly skin and wound assessments for resident #009 completed between specific dates March and June 2020 there was no indication that the resident was assessed weekly for their identified alteration to skin integrity for several specific dates in April, May and June.

A review of the progress notes further indicated that resident #009 sustained a change in altered skin integrity to an identified body part on specific date in June 2020. There was no documentation to support the resident's altered skin integrity was assessed by the registered staff on identified date in June 2020.

In relation to residents #027 and #062:

A complaint was received by the Director through a Military observation report, identified date in May 2020, entitled "OP Laser - JTFC Observations in Long Term Care Facilities in Ontario", #3350-Op Laser 20-01 (COS). In relation to Altamont LTCH, the report indicated the Military staff members had several concerns related to the skin and wound care practices in the home and indicated the following:

"1(b) Significant number of residents have identified skin conditions as a result of prolonged bed rest...
1 (c) At time of arrival many of the residents had been bed bound for several weeks; No evidence of residents being moved to wheelchair for parts of day, repositioned in bed, or washed properly..."

During an interview with the first military clinical group on specific date in June 2020, revealed they had not observed staff assisting residents with activities of daily living (ADL) like toileting or repositioning during the specific dates in March and April 2020,

In relation to resident #062:

Inspector #672 reviewed resident #062's skin and wound care assessments and progress notes related to skin care documented between March 1 and June 24, 2020, and observed on identified dates in March, April, May and June 2020, resident #062 was noted to have eight new multiple skin conditions on different identified body parts.

During a review of the weekly skin and wound assessments for resident #062 completed between identified dates in March and June 2020, there was no indication that the resident was assessed weekly for their identified alteration to skin integrity for several specific dates between March and June 2020.

In relation to resident #027:

Inspector #672 reviewed resident #027's skin and wound care assessments and progress notes related to skin care documented between specific dates between March and June 2020, and observed the following specific skin conditions. Through May until June resident #027 was noted to have five skin conditions plus six additional new skin conditions. There was no indication that the resident was assessed weekly for their identified alteration to skin integrity in May 2020.

During an interview, the Skin and Wound Care Coordinator/Chanmpion (SWCC) indicated they were responsible for completing the weekly skin and wound assessments for all residents in the home with skin conditions, which they were scheduled two days per week to complete. The SWCC further indicated they struggled to complete all of the weekly skin and wound assessments during that time frame, due to the amount of skin conditions, in the home. Due to the time constraints, the SWCC indicated there were times when they would assess a resident's skin condition(s), on one day and document

the assessments on another. The SWCC further indicated there were other times when they would split the assigned weekly skin and wound assessments, therefore couldn't be sure of which assessments had actually been completed on the dates listed on the skin and wound assessments, because they had not documented any of the assessments as a late entry.

The licensee failed to ensure that residents #009, #027 and #062 were reassessed at least weekly by a member of the registered nursing staff when the resident was exhibiting altered skin integrity, which included specific skin conditions, between specific dates in March and June 2020. [s. 50. (2) (b) (iv)]

2. The licensee has failed to ensure that the resident who is dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

This Inspection Protocol (IP) was initiated based on the CAF's observation report, dated May 2020, outlining a lack of repositioning and prolonged bed rest resulting in deteriorating skin conditions. Military arrived in the home on identified date in April 2020.

Ministry Inspectors arrived on site on May 21, 2020. Inspector #672 identified that residents remained in bed for the duration of the day and on subsequent identified dates in May and June 2020 days, upon further observations.

Resident #033.

Resident #033's written plan of care identified that two team members are to repositioning the resident every two hours.
A record review of April-May 2020 documentation by PSWs failed to confirm the repositioning task for the resident was completed as per an identified schedule of every two hours.

A record review identified a skin and wound assessment on identified date in March 2020, identifying resident #033 skin condition on an identified area. A treatment note of the skin condition, four days later was documented by RPN #152 with further notes on identified dates in March and April 2020, that identified no significant changes in the resident's skin condition.

A review of the home's staffing schedule and interview with staffing coordinator revealed staff shortages to the wing starting April 6, 2020. From identified dates in April 2020, regular shortages of PSW staff and registered nursing staff were identified, often with half the number of PSWs on a specific shift as compared to the home’s staffing plan.

An interview with PSW #219 who was scheduled up until identified date in April 2020, on a specific shift, identified they often worked short with two PSW and were unable to reposition the resident every two hours. PSW #194 who worked until an identified date in April 2020, identified that the repositioning care task could not be completed for all residents. The staff recalled resident #033 and stated they would see them in the same position until the end of their shift and sometimes with two staff, especially with agency staff, the specific care task could not be completed.
In separate interviews RPN #152 and RPN #156 identified that resident #033’s scheduled repositioning was not being completed as required when the unit was short staff and with only two PSWs working resident's remained in bed. Both RPNs separately identified that between medication passes they would identify the resident in the same position which would indicate the resident was not repositioned.

A final record review identified that on a date in April 2020, the resident's skin condition had deteriorated and in April 2020, was documented as a worsened specific skin condition. A note in April 2020, revealed that resident was crying with pain from the skin condition treatment. On identified date in April 2020, a skin and wound assessment note by RPN #152 confirmed a deteriorated skin condition and that the resident displayed signs of pain during the treatment.

An interview with the ADOC #137 revealed that when the wing was short staffed the priorities were other specific ADLs and that resident’s remained longer in bed and were not getting up after a specific shift had place them back in bed. The ADOC confirmed that resident #033’s skin condition had deteriorated and they had not been repositioned as required.

3. An area of non compliance was identified with r. 50.(2) (d) , as per policy, the sample size was expanded and included residents #077 and #062.

Resident #077

Resident #077 was admitted to the home on a date in March 2020. A review of the resident's admission assessment in March 2020, identified the resident's skin integrity healthy and intact.

Documentation through POC identified a skin observation of altered skin integrity of an identified area in April 2020, with no further alterations in skin integrity noted up until May 2020, where the resident's altered skin integrity was reported to the a registered staff. A progress note by a registered nurse in May 2020, revealed knowledge of the reported skin condition. The next documentation was a skin and wound assessment in June 2020, revealing a worsening skin condition.

A review of the resident's admission MDS assessment in March 2020, stated the resident required extensive assistance with the identified repositioning every two hours and the specific level of assistance.

In separate interviews PSW #174 and PSW #214 shared that resident #077 required scheduled repositioning. PSW #214 shared the resident did not have a visual indicator for the need to reposition of every two hours and that the resident spent more time in bed when the wing was short staffed. The PSW stated the resident would lie in a specific position in bed. An interview with PSW #117 stated that when the wing had only 2 PSWs the residents were not taken out of bed into a chair for their meal and remained in bed and unable to reposition every two hours.

An interview with PSW #211 confirmed they worked a specified shift in April, 2020 and that the prior shift staff would ensure the resident was cleaned and in bed before the end of their shift. The staff stated when they were short staffed on their shift resident #077 did not get out of bed. The staff shared awareness that the resident required physical assistance and repositioning when in bed but that they were unable to provide repositioning as often as required.

A review of the resident's plan of care failed to identify a requirement for the resident to be repositioned every two hours.

An interview with the ADOC #137 stated that resident #077 did require repositioning by staff every two as they were unable to reposition themselves in bed. The ADOC also revealed there was nothing in the documentation system to alert staff to the resident's need for repositioning as it was missed being entered.

A further interview with the ADOC confirmed that when the PSW staffing levels were critically short, the focus was on other specified care interventions and not repositioning this resident required. In addition this resident spent more time in bed, identifying both contributing to the deterioration of the resident's skin condition over a short period of time.

Resident #062

Resident #062's written plan of care identified an specific number of team members were to provide care at all times; the resident was to receive scheduled repositioning, as per identified posting on the overhead wall, when the resident was in bed, related to their skin condition.

A record review of April-May 2020 documentation by PSWs failed to confirm the resident was repositioning every two hours.

An interview with PSW #221 who worked full time on the specified shift up until an identified date in April 2020, identified the wing was often short with two PSWs for 35 residents and they were unable to provide scheduled repositioning every two hours.

In separate interviews RPN #152 and RPN #156 identified that resident #062 was not being repositioned as required when the unit was short staff with two PSWs and that it contributed to their deteriorating skin condition. Both RPNs, who worked full time most of April, separately identified that between medication passes they would identify the resident in the same position which would indicate the resident had not been repositioned every two hours. RPN #152 also shared that resident #062 had a tendency to be in a certain position which aggravated their skin condition and required staff to continue to provide repositioning which was not occurring. The RPN confirmed that unless a resident was independent and could get up on their own, residents, like resident #033 remained in bed when the wing was short staffed.

A review of the home's staffing schedule and interview with staffing coordinator revealed staff shortages to the unit starting on identified date in April 2020. From 19 identified dates in April 2020, regular shortages of PSW staff and registered nursing staff were identified, often with half the PSW staffing levels on a specified shift.

A record review in April 2020 revealed a 'Skin and Wound Care Assessment' that identified the resident's skin condition had significantly deteriorated from the prior

assessment in April 2020.

An interview with ADOC #137 revealed that when the unit was short staffed the priorities were other specific care interventions and that residents remained longer in bed and were not getting up after specific shift had place them back in bed. The ADOC confirmed that resident #062s skin condition had deteriorated and they had not been repositioned every two hours as was required.

4. Related to Log #010420-20:

A Critical Incident Report (CIR) was submitted to the Director related to an alleged incident of staff to resident neglect of resident #009 which occurred on identified date and time May 2020. The CIR indicated on identified date and time in May 2020, resident #009 transferred to another room on the same wing. The room change was not communicated to the next shift. On the morning of an identified date in May 2020, the PSWs on duty were unaware of the resident's whereabouts, as the nameplates on the outside of the resident bedrooms had not been transferred and the door to resident #009's new room had been left closed, therefore the staff were unaware the resident resided within, as the bedroom had been empty for the previous three or four days. The PSW and identified RPN began searching for the resident and located the resident approximately half an hour later. This led to resident #009 not receiving specific care interventions for the identified time.

During separate interviews, RPNs #130, #145, #148 #152 and #212 along with PSWs #101, #108, #117 and #120 indicated resident #009 was identified risk for altered skin integrity and required repositioning to protect their skin and prevention of worsening skin integrity.

During record review, Inspector #672 reviewed resident #009's current written plan of care and MDS assessment, which indicated the resident required a level of transfer assistance, care interventions, identified nutritional risk, level of cognition, identified medical and clinical conditions. Inspector #672 also reviewed resident #009's documentation and observed there were no support actions documented related to resident #009 being provided scheduled care interventions.

During a record review, Inspector #672 reviewed the daily shift rosters between identified dates May and June 2020, and noted that during that time, the home had more than their

full complement of staff on duty. The home was fully staffed by their regular duty Altamont staff members and were also receiving additional staffing assistance and support provided from the clinical and environmental Canadian Armed Forces (CAF) Military staff members until identified date June 2020; a contracted staffing agency, and Centenary Health Network personnel. These additional supports led to the home having several more staff members than their usual staffing complement available on every wing within the home to assist with both clinical and environmental tasks. Inspector #672 then reviewed the internal resident census list and observed that during that same time, the home had just over half of their usual resident census.

During a record review, Inspector #672 noted that resident #009 had a change in condition and was not in the home between identified dates in May and June 2020.

When the resident returned to the home resident observations were made by Inspector #672 between identified dates May and June 2020. Two identified dates in May and two identified dates June 2020, resident #009 did not receive scheduled care
In order to expand the scope of assessment, along with following up on concerns raised in the Canadian Armed Forces (CAF) report from Inspection #2020_715672_0008, Inspector #672 began observing residents #027, #062 and #077 related to being provided specific and scheduled care interventions.

During an interview with the identified military clinical group on identified date June 2020, they identified staff not assisting residents with identified care interventions during the identified dates March to April 2020.

In relation to resident #027:

During a record review, Inspector #672 noted that resident #027 required an identified level of transfer assistance and repositioning every two hours.
Inspector #672 also reviewed resident #027's documentation and there was nothing in the documentation system to alert staff to the resident need for repositioning.

Inspector #672 reviewed resident #027's skin and wound care assessments and progress notes related to skin care documented between March and June 2020.
On a date in April 2020, resident #027 was noted to have three new skin conditions on identified body areas.

On four dates in May 2020, resident #027's documentation revealed three areas of

altered skin integrity were noted to have deteriorated with one new area.

On four dates in June 2020, resident #027's documentation included two new areas of altered skin integrity and two previous areas that had deteriorated.

During resident observations made by Inspector #672 between May and June 2020, on five occasions, resident #027 was not repositioned.

On an identified date in June 2020, resident #027 was transferred from another wing. The resident was observed to be sitting up in wheelchair. Hours later the resident was still sitting up in wheelchair, had not been repositioned and was complaining of severe pain. This was passed along to RPN #172, who provided resident with pain medication. Hours later the resident was still sitting up in wheelchair; had not been repositioned and continued to complain of pain. This was passed along to staff and PSW #177 repositioned the resident and resident stated they felt much better.

In relation to resident #062:

During record review, Inspector #672 observed that resident #062 required identified level of transfer assistance, care interventions, identified nutritional risk, level of cognition, identified medical and clinical conditions. Inspector #672 also reviewed resident #062's Point of Care (POC) documentation and observed there were no support actions documented related to resident #062 being provided scheduled care interventions.

Inspector #672 reviewed resident #062's skin and wound care assessments and progress notes related to skin care documented between identified dates March and June 2020, and observed the following specific to altered skin integrity:
- On identified date March 2020, resident #062 was noted to have one skin condition on identified body area.
- On identified date April 2020, a referral was sent to the Registered Dietician requesting assessment and further nutrition related interventions for resident #062 as the skin condition on identified body area.
- On three identified dates May 2020, resident #062 was noted to have three new skin conditions on identified body areas and one skin condition on identified body area had worsened.
- On two identified dates June 2020, resident #062 was noted to have a one new

skin condition on identified body area and one skin condition on identified body part had worsened.
- On identified date June 2020, a referral was sent to the Registered Dietician requesting assessment and further nutrition related interventions for resident #062 as the skin condition on identified body area was noted to have worsened. Resident #062 was also noted to have a new skin condition on identified body part

During resident observations made by Inspector #672 between identified dates June 2020, on five occasions resident #062 was not provided scheduled care interventions between specific time frames.

During an interview in June 2020 PSW #176 indicated the expectation in the home was for residents to be repositioned at a minimum of every two hours when the resident was in bed. If a resident was sitting up in a wheelchair, they were not required to be repositioned. PSW #176 further indicated that morning they had been assigned to resident #062 and the resident had been assisted up to their wheelchair at and had not been repositioned until the resident was transferred back to bed 6 hours and 45 minutes later.

During an interview, PSW #185 indicated the expectation in the home was for residents to be repositioned at a minimum of every two hours when the resident was in bed but if a resident was sitting up in a wheelchair, they were not required to be repositioned. PSW #185 further indicated that they had been working with resident #062 almost daily for the previous two weeks and the resident was the first or second resident they would assist with personal care and transfer to the wheelchair in the morning, which led to the resident sitting up in the wheelchair daily from approximately 0650hrs until the resident would be assisted back to bed in the afternoon, without being repositioned during that time.

In relation to resident #077:

During record review, Inspector #672 observed that resident #077 required identified level of transfer assistance, care interventions, identified nutritional risk, level of cognition, identified medical and clinical conditions. Inspector #672 also reviewed resident #077's documentation and observed there were no support actions documented related to resident #077 being provided scheduled care interventions.

Inspector #672 reviewed resident #077's skin and wound care assessments documented between March and June 2020, and observed the following specifics to altered skin integrity.
Resident #077 moved into the home on identified date in March 2020 with no skin concerns.
On four identified dates in June 2020, resident #077 was noted to have a one area of altered skin integrity worsen.

During resident observations made by Inspector #672 in June 2020, on four occasions resident #077 was not repositioned every two hours.

During an interview, the RAI Coordinator verified there was no documentation by the PSWs to indicate resident's #009, #027, #062 or #077 required or received care repositioning every two hours, as per the resident's written plan of care.

During an interview on identified date June 2020, PSW #185 indicated resident #077 only required scheduled care interventions at certain times and at the identified time resident #077 had been assisted up to their wheelchair at the identified time and had not been repositioned until approximately six hours later.

During separate interviews, PSWs #117, #120, #121, #124, #127, #174, #177, #191, #213, #214 and #216 indicated the expectation in the home related to resident repositioning was for residents to be repositioned at a minimum of every two hours while in bed but did not require repositioning when sitting up in a wheelchair, which could lead to a resident sitting in the same position for multiple hours in a day.

During separate interviews, PSWs #110, #116, #216, #132, #108, #186, #181 indicated the expectation in the home related to resident repositioning was for residents to be repositioned at a minimum of every two hours while in bed or when up in a wheelchair, it did not matter the resident??s location.

During separate interviews, the SWCC, ADOC #137, DOC #150 and the Corporate Clinical Consultant indicated the expectation in the home related to resident repositioning was for residents to be repositioned at a minimum of every two hours while in bed or when up in a wheelchair, it did not matter the resident??s location.

The licensee failed to ensure that residents #009, #027, #062 and #077, who were dependent on staff for repositioning, were repositioned at a minimum of every two hours. [s. 50. (2) (d)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(e) is approved by a registered dietitian who is a member of the staff of the home; O. Reg. 79/10, s. 71 (1).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee of a long-term care home failed to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home.

This IP was initiated in response to the Canadian Armed Forces (CAF) Observation Report dated May 14, 2020 of inadequate nutrition due to significant staffing issues and most residents were reported as not having received three meals per day.

An interview with the Director of Dietary Services (DDS) identified the entire home went onto tray service March 31, 2020 that they continued with preparing the regular menu but removed a regular item from the menu, referred to as Item A in this report. The DDS stated they had not consulted the home's RD around the decision to remove Item A from the menu.

The Ministry of Long Term Care received a family complaint that resident #028 was not provided three meals a day and was complaining of being hungry.

An interview with full time PSW #116 and PSW #205 confirmed that resident #028 often only consumed Item A at meals and would not eat anything else. An interview with RPN #136 identified the resident's cultural backgound, does not like the taste of the food in the home and that the resident complains about the taste but will take Item A.

An interview with resident #028, by way of translator PTA #102, revealed they missed Item A when it was removed from the menu.

A record review of the Weight Summary Report identified the resident lost weight over two identified months.

An interview with the RD confirmed they were unaware that Item A had been removed from the menu and that it's removal had not been prior approved. [s. 71. (1) (e)]

2. The licensee has failed to ensure that all resident's received three meals per day.

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report dated May 14, 2020 of inadequate nutrition due to significant staffing issues and most residents were reported as not having received three meals per day.

Resident #020 was identified at high nutritional risk at the RD's last assessment. The assessment identified the resident's diet type which included both food and fluids and their dependence on staff for eating.

On an identified date, months after the RD's assessment, an interview was conducted with CAF personnel. The personnel reported that when they arrived to the home they observed staff serving resident #020 only fluids at meals, three labelled cups, and no food. The staff identified that they assisted the resident with a full meal, that the resident was receptive and ate 100% of the meal provided.

On an identified date Inspector #672 conducted the following observations of resident #020 at lunch.
1245hr resident was served their lunch meal tray.
1308hr no assistance provided; resident asleep in their chair.

1310hr Inspector asked RPN #130 if someone was assigned to assist resident #020, and the RPN replied yes.
1318hr resident was still unassisted and Inspector reapproached the RPN. PSW #108 was sent in.
1321hrs PSW #108 exited the resident's room and informed RPN #130 that resident had taken their lunch. The tray remained in the resident's room.
1322hrs Inspector entered resident’s room and observed the resident's meal tray. All lids with a secured label were untouched, dessert pudding cup unopened and it appeared that entree meal and soup were untouched.

Inspector #672 overheard PSW #108 inform RPN #130 that the resident had their lunch.

A review of resident #020's meal and fluid intake for lunch on the identified day observed, reported in the PCC 'Look Back Report' was blank.

An interview, by Inspector #672, with PSW #104 on the following day, revealed that they could not remember but they thought the resident "ate pretty good for them" and "I'm pretty sure they drank well". Inspector #672 shared that the resident's tray had been inspected after the PSW left the resident's room and that the staff had reported the resident had their lunch to RPN #130.

An interview, by Inspector #672, with RPN #130 confirmed awareness that PSW #108 was asked to assist resident #020 with their lunch meal and recalled PSW #108 reporting back that the resident ate their meal.

A record review of the Weight Summary Report identified the resident's weight status was high risk and had a further weight loss over an identified two month period.

The licensee failed to provide resident #020 with three meals per day. [s. 71. (3) (a)]

3. The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.

Resident #001

A complaint was received by the Director on April 14, 2020, from resident #001's family member, which indicated the resident was unwell and not offered adequate hydration.

During a telephone interview with resident #001's family member/complainant, they indicated that while resident #001 was in the home and ill, the resident would complain they were often thirsty, as it would take extended periods of time for staff members to respond to the call bell when they would request a drink. According to the complainant, they would also call into the home to attempt to get a staff member to bring resident #001 a drink. On an identified date, the complainant contacted emergency services on their own and initiated the transfer of resident #001 to the local hospital. Resident #001 was admitted to the hospital, where they passed away.

During a record review, Inspector #672 observed over multiple days in an identified month,leading up the resident's transfer to hospital, resident #001 was documented to have consumed less than half of their required fluid intake. A review of resident #001's hospital record, admitting diagnosis, included a diagnosis consistent with poor fluid status.

During separate interviews, PSWs #117, #120, #121 and #174 indicated that resident #001 had become ill and often complained they could not tolerate the food being served. PSWs #117, #120, #121 and #174 further indicated that resident #001 would often complain of thirst and had a water jug kept at the bedside, which staff tried to keep full, but due to staffing concerns around that time, indicated it was difficult to ensure "small tasks like that were being done when we were just trying to make sure everyone was clean and fed".

A review of the home's hydration policy, dated April 2019, identified the residents are to be offered a minimum of 1500-2000 ml of fluid daily unless specific care plans indicate an individualized fluid goal. The standard included that fluids were to be offered as follows:

Breakfast - 250ml milk, 125ml juice, 180ml water, 180 ml tea and coffee
Morning Snack- 125 ml cold beverage (fruit drink/water/milk) or 180 ml tea and coffee
Noon Meal -125ml milk, 180ml water, 125ml fluid as soup or juice, 180 ml tea and coffee
Afternoon Snack- 125 ml cold beverage (fruit drink/water/milk) or 180 ml tea and coffee
Evening Meal- 125ml milk and tomato juice, 180ml water, 180 ml tea and coffee
Evening Snack - 125 ml cold beverage (fruit drink/water/milk or 180 ml tea and coffee

Resident #063 interview by Inspector #110.

An interview with resident #063 revealed they were never offered milk and liked milk to

drink. The resident shared they would drink milk especially since they have been given orange juice at every meal and have become tired of it.

A review of the home's hydration, policy #XI-G-20.00, dated April 2019, identified the residents are to be offered a a minimum of 1500-2000 ml of fluid daily unless specific care plans indicate an individualized fluid goal. The standard included milk to be offered as follows:

Breakfast - 250ml milk
Morning Snack- 125 ml cold beverage (fruit drink/water/milk) or 180 ml tea and coffee
Noon Meal -1/2 cup 125ml milk
Afternoon Snack- 125 ml cold beverage (fruit drink/water/milk) or 180 ml tea and coffee
Evening Meal- 1/2 cup 125ml milk or tomato juice
Evening Snack - 125 ml cold beverage (fruit drink/water/milk or 180 ml tea and coffee

On May 22, 2020, Inspector #672 observed that lunch meal trays were served with one 200ml juice box and the nearby beverage cart did not include milk.

PSW #108 stated 'the carts never have milk on them enough to be served to residents as a drink, only a small jug for mixing for tea/coffee. Further observations were consistent with milk not being offered.

Interviews with PSW #211 and #235, who worked between April and May 2020, confirmed that milk was not available or served as a drink at meals and snacks and PSW #235 stated they were only provided a 1L milk jug for upwards of 35 residents at mealtimes on the cart.

An interview with the RD confirmed that milk was part of the planned menu and hydration program and that milk was to be offered to residents. [s. 71. (4)]

4. Inspectors #110 and #672 arrived onsite of the LTCH on May 21, 2020. Inspector #672 observed multiple nourishment passes and meal services noting that planned menu items were not offered and available at each meal or snack for multiple residents in the home between May 21 and June 30, 2020.

May 21, 2020 – Afternoon snack -Wing 4
Not all residents were offered fluids according to the planned menu. PTA #102 stated PSWs usually serve residents who ask for a drink or if they have a specialty drink sent

from the kitchen.

May 22, 2020 – Morning snack -Wing 3
PSWs were not observed offering every resident a drink from the cart according to the planned menu. PSW indicated to Inspector that a drink is provided to the resident "if we know they always like a cup of tea/coffee at this time of day, if they ask for a drink or if they have a specialty drink sent from the kitchen".

May 22, 2020 -Lunch Service Wing 4
Meal trays were served with 1 serving of fluid, a 200ml juice box.
There was a small cart delivered along with the meal tray cart containing 1 pot of tea, 1 pot of coffee, 1 jug of juice and 1 small jug of water. No milk was present.
There were approximately 32 residents on Wing 4 at this time.
Fluids were observed not being offered to all residents with their meals according to the planned menu. PSW #108 stated the fluids on the small cart (tea/coffee/juice/water) were provided "if a resident asked or for the residents they know want tea/coffee with their meal, but not all do ask". PSW #108 also stated the carts "never" have milk to be served to residents as a drink, only a small jug for mixing with tea/coffee.

May 22, 2020 -Lunch Service Wing 3
Meal Trays were served by 1305hr, most residents were served 1 serving of fluid, a 200ml juice box with their tray. PSWs indicated they only serve fluids from the small beverage cart to those residents who ask for another drink with their meal, or for the residents they know like a cup of tea/coffee. The accompanying fluid cart had 1 jug of tea/coffee/water. No juice or milk was present. PSW #106 indicated the cart "never" has milk on it with the intention to be served to residents as a drink, only to be mixed with tea/coffee.

May 22, 2020 – Afternoon snack Wing 4
Residents, #029, #031, #030, #019, #021, #027, #047, #048, #020 and #026 were not offered a drink during the afternoon snack pass in keeping with the planned menu.

May 22, 2020 – Afternoon snack observation Wing 3
Residents #049, 041, 050, 037, 017, 028 and 006 were not offered a drink during the afternoon snack pass in keeping with the planned menu.

May 25, 2020 – Afternoon snack observation Wing 4

Eight residents were not offering a drink during the afternoon snack pass in keeping with the planned menu.

Wing 3
Resident #029 was not offered a drink and PSW #108 stated the “resident didn’t ask for a drink and doesn’t normally get one at this time of the day”. Following the Inspector’s question the PSW served the resident a drink which was all consumed.

May 25, 2020 -Dinner observation Wing 3
1740hrs - All dinner trays were prepared and sent to the wings with 1 juice box 200ml on each tray and a prepacked meal in a disposable box with disposable cutlery. A beverage cart was sent along with the trays. The beverage cart consisted of 1 pot of tea/coffee/decaf coffee and 1 very small jug of water, 2 -237ml cartons of 2% milk, which the PSW indicated was to be used to mix with tea/coffee and not as a drink option of the residents.
Both during and after the meal, staff were observed not offering the residents any additional fluids from the small beverage cart leaving residents, including residents #017, #073, #060, #037, #043, #074, #072, #041, #050 and #071 who receiving 1-200ml juice box with their meal and were not offered the planned menu items of 125ml milk and tomato juice, 180ml water, 180 ml tea and coffee.

Wing 4
Staff were observed not offering all of the residents fluids from the beverage cart leaving residents to receive 1-200ml juice box as their fluid with their meal. PSW #173 indicated staff only served additional fluids outside of the juice box on the meal tray to residents who staff “knew they liked tea/coffee with meals” or “if the resident asked”. Residents were not offered the planned menu.

On May 26, 2020 after several observations by Inspector #672 a conversation took place between Inspectors #110 and #672 and the Director of Dietary Services #104 and Sienna Clinical Supervisor #103 around residents being offered one 1- 200ml tetra box of juice each meal tray and not following the home’s hydration policy or planned menu.

May 27, 2020 -Lunch Observation
Lunch meal trays on 3 units were still being served with only 1 juice box (200ml) present on the tray and not being offered the planned menu for fluids outside of a 200ml juice box.

May 27, 2020 -Afternoon snack pass
Residents were observed not being offer a drink in keeping with the planned menu at the afternoon snack pass.

May 30, 2020 – Lunch Observation
Twelve residents, including resident #039 were observed being served their meal tray with empty cups which remained unfilled throughout the lunch service. Resident #039 was overheard, very loudly calling out for a drink at 1315hrs, but staff did not respond to the resident's request.

On June 1, 2020 Inspector #672 observed seven resident's including resident #024 not being offered a drink or snack at the afternoon snack pass according to the planned menu. At 1529hr resident #024 was overheard loudly calling out into the hallway stating they were very thirsty and requesting a drink. Staff did not respond to the resident's request until 1542hr, when Inspector asked PSW #139 if the resident would be provided with fluids and/or a snack. The resident was observed then being provided with a drink, consuming it immediately and then asking for another.

On June 1, 2020 at 1610hrs a second conversation took place between the acting ED #140, Sienna Clinical Supervisor #103 and Inspectors #110 and #672 that residents were still not being offered drinks according to the planned menu. [s. 71. (4)]

5. Resident #020:

During a record review, resident #020 was noted to be at high nutritional risk for reasons that included their weight status and risks of dehydration. The resident was also at high risk for heat related illness and therefore required fluids to be encouraged. The resident was identified as requiring staff assistance for food and fluid intake.

Observations of resident #020 over a three week periods revealed that resident #020 was not offered the planned menu items, including fluids, at each meal and snack on ten separate occasions.

Resident #029:

During record review, resident #029 was noted to be at moderate nutritional risk for reasons that included their weight status and increased fluid needs. Resident #029 was at high risk for heat related illness and therefore required fluids to be offered and

encouraged. The resident was identified as requiring staff assistance for food and fluid intake.

Observations of resident #029 over a week period revealed that resident #029 was not offered planned menu items, including fluids, at each meal and snack on six separate occasions.

Resident #030:

During a record review, resident #030 was noted to be at high nutritional risk for reasons that included their weight status. The resident was identified at high risk for heat related illness, therefore required fluids to be encouraged. The resident was identified as requiring staff assistance for food and fluid intake.

Observations of resident #030 over a three week period revealed that resident #030 was not offered planned menu items, including fluids, at each meal and snack on six separate occasions.

Additional observations over the course of the inspection identified 27 other residents who were also not offered planned menu items on multiple occasions, including fluids, at each meal and snack.

During separate interviews, PSWs #101, #108, #110, #116, #117, #127, #132, #139, #181, #183 and #185, RPNs #115, #130, #212 and PTA #102 indicated residents were only served fluids during nourishment passes or additional fluids outside of the 200ml tetra juice boxes during meals if a resident asked or for the staff knew the residents wanted tea/coffee with their meal. Several PSWs also stated the fluid carts “never” had milk on them to be served to residents as a drink, staff only had a small carton for mixing with tea/coffee.

During separate interviews, the Acting DOC, Acting ADOC, Corporate Clinical Consultant, Acting Executive Director and the FSM indicated the expectation in the home was for every resident to be offered a drink and snack during every nourishment pass and additional fluids as well as the 200ml tetra juice boxes served during meals according to the internal nutrition and hydration policy.

The licensee failed to ensure that planned menu items were offered to multiple residents

between May 21 and June 17, 2020, at each meal and snack. [s. 71. (4)]

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector". VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle is approved by a registered dietitian who is a member of the staff of the home, to be implemented voluntarily.

WN #9: 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).

Findings/Faits saillants :

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

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report, dated May 14, 2020, outlining several concerns related to the skin and wound care practices in the home. Specifically, a significant number of residents had areas of altered skin integrity as a result of prolonged bed rest. Fifteen residents had areas of altered skin integrity that required significant care plan with treatment orders not updated nor adhered to by agency staff causing further degradation of areas of altered skin integrity; wound care nurse scheduled to visit every Wednesday for treatment, was unable to be onsite in the two weeks preceding the report, resulting in a significant deterioration of areas of altered skin integrity.

During an interview on June 4, 2020, clinical staff members indicated resident #062 had an area of altered skin integrity which had worsened and also experienced new related skin injuries during the pandemic.

Resident #062 was admitted to the home in 2019.

During a record review, Inspector #672 reviewed resident #062's skin and wound care assessments completed between February 2020, and June 2020, and noted on an identified date in February 2020, the resident was noted to have areas of altered skin integrity and was at risk for further skin conditions.

Inspector #672 reviewed resident #062's written plan of care in April, 2020, along with their current written plan of care and noted both plans indicated resident #062 level of staff assistance for ADL's, the need for therapeutic skin protecting aides and required scheduled care interventions/aide all related to the areas of altered skin integrity.

Inspector #672 observed resident #062 multiple times over a five week period and did not observe the resident to have the therapeutic skin protecting aides nor the scheduled care aide, to remind/direct staff members when the resident required the scheduled care.

During separate interviews, PSWs #185 and #176 indicated they were the primary caregivers for resident #062 during the day shift and were unaware of resident #062 requiring the therapeutic skin protecting aides or scheduled care interventions.

During separate interviews on June 25, 2020, PSWs #177 and #211 indicated they were the primary caregivers for resident #062 during the evening shift and could not recall the last time resident #062 had utilized the therapeutic skin protecting aides. PSWs #177 and #211 further indicated that resident #062 had been transferred to a new bedroom, but did not have their personal belongings transferred with them, which included a previously posted scheduled care intervention aide above their bed. PSW #177 indicated they had requested "several times" for scheduled care interventions aide to be posted for resident #062, but as of that time, the scheduled care interventions aide had not been posted.

During separate interviews, the Corporate Clinical Consultant, the SWCC, Acting DOC, Acting ADOC, RAI Coordinator and DOC indicated the expectation in the home was for residents to have care provided to them as per the care specified in the resident's plan of care. The Corporate Clinical Consultant, RAI Coordinator and DOC further indicated the expectation in the home was for resident's plan of care to be reviewed and revised if the care listed within the plan was no longer required by the resident, to ensure the plans

provided clear and concise directions for the staff members providing the care to the resident.

The licensee failed to ensure that the care set out in resident #062's plan of care was provided to the resident as specified in the plan, by not ensuring the resident was provided with therapeutic skin protecting aides and required scheduled care interventions/aide on a daily basis to provide direction to the staff members related to how/when to provide scheduled care to the resident while in bed. [s. 6. (7)]

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 there is a written plan of care for each resident that sets out the planned care for the resident, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 35. Foot care and nail care

Specifically failed to comply with the following:

s. 35. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives preventive and basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection. O. Reg. 79/10, s. 35 (1).

s. 35. (2) Every licensee of a long-term care home shall ensure that each resident of the home receives fingernail care, including the cutting of fingernails. O. Reg. 79/10, s. 35 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents received basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection.

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report, dated May 14, 2020, outlining several concerns related care. Specifically, the current staffing at the home, did not allow for more care than the most basic daily

requirements. Residents are changed and fed, however no ability to provide nail care, skin care, repositioning nor adequate wound care.

During resident observations between May and June, 2020, Inspector #672 identified 15 residents with toenails appearing long and dirty with brown material caked beneath the nail and dirt/grime between their toes.

On an identified date resident #022 was also observed to have toenails so long they were beginning to curl under the toe(s).

During separate interviews, PSWs #108, #109, #120, #127, #132, #177, #181, #185, #186, #192, #213, #214 and #216 and RPNs #130, #152, #193 and #212 verified at the time of Inspector #672's observations that the observed residents required toenail care, related to cutting and cleaning beneath the toenails. The PSW staff indicated they were not responsible for completing toenail care in the home specific to cutting the toenails, as it was outside of the PSW role/responsibilities, but they could clean beneath the nails and were responsible for ensuring resident's feet/toenails were kept in a clean and sanitary condition. RPNs #130, #152, #193 and #212 verified registered staff could complete toenail care for residents in the home who required assistance with their nails.

During a record review, Inspector #672 reviewed the daily shift rosters between May 26 and June 29, 2020, and noted that during that time, the home had more than their full complement of staff on duty. The home was fully staffed by their regular duty Altamont staff members and was also receiving additional staffing assistance and support provided by support from the clinical and environmental Canadian Armed Forces (CAF) staff members until June 18, 2020; a contracted staffing agency and through the Centenary Health Network personnel. These additional supports led to the home having several more staff members than their usual staffing complement available on every wing within the home to assist with both clinical and environmental tasks. Inspector #672 then reviewed the internal resident census list and observed that during that same time, the home had just over half of their usual resident census.

On May 30 and June 3, 2020 the Acting DOC #100 was advised of the Inspectors observations. On June 22, 2020 the ADOC #137; June 26 the DOC and June 30, 2020 the Corporate Clinical Consultant #103 were also advised of identified residents and the condition of their nails.

During separate interviews, the Acting DOC, Acting ADOC, DOC, ADOC #137 and the

Corporate Clinical Consultant indicated the expectation in the home was for toenail care to be provided to every resident as required, but should be assessed at a minimum of twice weekly on the resident's bath/shower day, and this service could be provided by the registered staff in the home, as the regular foot care nurse was unable to currently attend the home due to the ongoing pandemic.

The licensee failed to ensure that multiple residents received toenail care, which included the cutting of fingernails, between May and June, 2020. [s. 35. (1)]

2. The licensee has failed to ensure that residents in the home received fingernail care, which included the cutting of fingernails.

During resident observations between May and June, 2020, Inspector #672 observed multiple residents, in excess of 10, that were observed on eleven separate days to have long and dirty fingernails.

During separate interviews, residents #007, #008, #022, #051, #055, #067 and #080 indicated they had complained to staff several times about their personal hygiene support and fingernail care to be lacking in the home and had requested assistance, but had not received the level of assistance required "for a long time".

During separate interviews, PSWs #108, #109, #120, #127, #132, #176, #177, #181, #182, #185, #186, #191, #192, #213, #214 and #216; CSA #184; recreation aide #187 and RPNs #130, #152, #193 and #212 verified at the time of Inspector #672's observations that the observed residents required nail care, related to cutting and cleaning beneath the nails and indicated the expectation in the home was for fingernail care to be provided to every resident, at a minimum of twice weekly on the resident's bath/shower day, and at any other time when the resident's nails were observed to be long, chipped and/or dirty. PSWs #108, #127, #132, #177, #181, #185, #213 and #214 further indicated nail care was often overlooked and/or not provided due to time constraints.

During record review, Inspector #672 reviewed the daily shift rosters between May 26 and June 29, 2020, and noted that during that time, the home had more than their full complement of staff on duty. The home was fully staffed by their regular duty Altamont staff members and was also receiving additional staffing assistance and support provided by support from the clinical and environmental Canadian Armed Forces (CAF) staff members until June 18, 2020; a contracted staffing agency and through the Centenary

Health Network personnel. These additional supports led to the home having several more staff members than their usual staffing complement available on every wing within the home to assist with both clinical and environmental tasks. Inspector #672 then reviewed the internal resident census list and observed that during that same time, the home had just over half of their usual resident census.

During separate interviews, the Acting DOC, Acting ADOC, DOC, ADOC #137 and the Corporate Clinical Consultant indicated the expectation in the home was for fingernail care to be provided to every resident, at a minimum of twice weekly on the resident's bath/shower day, and at any other time in between, when the resident required nail care.

The licensee failed to ensure that multiple residents received fingernail care, which included the cutting of fingernails, between May 26 and June 30, 2020. [s. 35. (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 residents received basic foot care services, including the cutting of toenails, to ensure comfort and prevent infection, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and

maintain continence.

The Ministry of Long-Term Care received a complaint alleging that resident #003, who required toileting assistance, was not being toileted as needed, as a result of reduced staffing. As a result, the resident subsequently began to self restrict their fluid intake to avoid urinating in a brief. The resident was transferred to the hospital and treated for an identified diagnosis and then discharged to another facility.

A record review identified the resident was not cognitively impaired and a telephone interview was conducted with resident #003. The resident shared that they began to restrict the amount of fluids they drank due to worrying about not receiving the required assistance to go to the washroom and confirmed there were times when they needed to go to the bathroom and were not assisted by staff. The resident identified a two week period of time prior to being transferred to the hospital, when they were not being toileted when needed. The resident stated that they were toileted once per day in the morning and did not have a choice other than voiding in their brief throughout the remainder of the day. The resident further indicated there were days when they were not toileted at all. A review of the hospital patient triage record and discharge summary identified that the resident was exhibiting identified symptoms, were not drinking or urinating and had been admitted to hospital due to an identified diagnosis.

The resident’s health record identified the resident as usually continent, used the toilet twice per shift; was aware of their urge to void and required and identified number of team members to transfer on and off the toilet.

A review of specified documentation was completed, which identified that resident #003 was 'continent or both continent and incontinent' with voiding on the toilet. Later documentation indicated the resident was 'incontinent' with no voiding on the toilet. The resident interview confirmed they remained continent, were unassisted to the toilet regularly or on request and had no choice other than to void in their brief, which supported the documentation of incontinent with no voiding on the toilet.

An interview with full time PSW #235 described the resident as cognitively very aware and required the assistance of an identified number of staff to the washroom in the morning, before lunch and that the resident would ask to use the toilet. The staff indicated it was not very often that the resident was incontinent.

During an interview, PSW #127 indicated resident #003 required assistance with toileting

and would attempt to transfer independently. When resident #003 was found to be attempting to self transfer, staff would assist them.

An interview with the evening shift RPN #145 identified that they transferred the resident to the hospital on a specified date. The RPN shared that the unit was often short staffed specific to PSWs on the evening shift with times when just one PSW would be on duty, instead of the planned three and there had been a lot of agency staff leading up to the resident's transfer to hospital. The RPN stated they recalled that on one shift when they provided the resident's medications around 1430hrs, the resident asked to use the washroom, which they reported to a PSW. RPN #145 indicated that when they returned to the resident at approximately 1730hrs to administer medications, the resident informed them that no one had come to take them to the washroom so the RPN assisted and the resident voided on the toilet.

An interview with NP #149 who assessed the resident related to staff reporting the resident was febrile, stated that during their assessment the resident asked to use the washroom revealing the resident remained aware to request toileting assistance.

A review of the staffing schedule identified PSW shortages on days and evenings consistently over an identified period of time. With days and evenings, covered by one PSW instead of three, who provided care to 19-21 residents on the wing, notably half the home’s staffing plan, especially during the identified time period.

The licensee failed to ensure that resident #003, who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence. [s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident who is unable to toilet independently some or all of the time receive assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure the nutrition care and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration.

This IP was initiated in response to the Canadian Armed Forces (CAF) Observation Report, dated May 14, 2020, of inadequate nutrition due to significant staffing issues and that most residents were reported as not having received three meals per day.

On March 31, 2020, all residents in four wings were placed on isolation precautions for a total of 153 residents and provided tray service.

The residents remained on tray service when the Inspectors left the home June 30, 2020.

Staff interviews with PSWs and registered staff throughout the inspection period

described the tray service process in that dietary staff rolled carts to the door of each wing but did not enter or participate on the wings. Initially for approximately 6 weeks the meals were served on disposable plates covered with plastic wrap, then for 4 weeks utilized cardboard folding takeout containers. There was no thermal system in place to keep hot food hot. The upright cart with trays was accompanied by a small beverage cart with containers of beverages to be served by PSW staff.

Interviews with PSWs and registered staff revealed that trayservice/ mealtimes was demanding. PSWs were required to distribute, feed/encourage residents with their meals along with offering and serving beverages. The PSWs would then remove and dispose of tray items and provided hygiene care to residents. When staffing was short, staff reported not all residents received the encouragement they required and the meal process was extended, taking up to 1.5-2 hrs to finish, causing some residents to receive cold food. The staff shared that breakfast would be finishing when the morning snack cart arrived. Similar comments were shared about each meal.

Staff interviews, the staffing schedule and resident records identified, for example, on the evening shifts of April 18, 21, 24-27, 2020, with 34-30 residents residing on wing 4, 1 PSW and 1 RPN were present for dinner meal service. According to the residents' plans of care and staff interviews (PSW #101, RPN #145) eight to ten residents required total feeding assistance with meals and seven to eleven required encouragement and supervision assistance with the remaining residents being independent with supervision.

Registered staff and PSWs revealed that inadequate staffing resulted in the meals taking longer to serve and residents not being hungry at snack service as meals and snacks ran into each other created meal/snack compression affect. Staff also reported being unable to offer beverages and/or snack at nourishment times because of limited staff and having to attend to other resident care needs.

An interview with the Director of Dietary Services shared they were not present on the wings to observe the process of tray or snack service and were unaware of the meal compression affect negatively impacting resident's intake or that snacks were not always being served. The DDS shared there was no discussion at management meetings of staffing levels during meals and that resident's were not receiving the assistance they required. The DDS was unaware that fluids, including milk, were not being offered and served according to the planned menu; hot food was cold and unpalatable to residents, and that a system to acknowledge resident's mealtime needs like dislikes to eggs, preference for milk and requiring straws for all fluids, was not in place.

An interview with the RD confirmed they were not on-site from April 7 until June 25, 2020. The RD acknowledged the presence of these risks in the nutrition and hydration program as it related to tray service that they went unidentified.

An interview with the DOC confirmed that there was a lack of leadership on the wings during meal service.

A review of the 'Weight Summary Report' identified 49 residents were weighed in May 2020, and 42/49 or 86 per cent of the residents lost weight between March 2020 and May 2020 including those residents not diagnosed with an identified illness.

The licensee failed to ensure the nutrition care and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration. [s. 68. (2) (b)]

2. The licensee failed to ensure that the nutritional care program includes the implementation of interventions to mitigate and manage identified risk to nutritional care.

This IP was initiated in response to the Canadian Armed Forces (CAF) Observation Report dated May 14, 2020 of inadequate nutrition due to significant staffing issues and most residents were reported as not having received three meals per day.

Resident #088 was triggered related to a significant weight loss over an identified two month period.

A weight review prior identified the resident’s weight as stable.

A record review identified that resident #088 was unwell on an identified date and a month later the illness was resolved. The resident’s meal intake reported on the Look Back Report over a two week period identified multiple occasions where the resident’s intake was reported as 0-25%. A Clinical Alert was identified on the electronic documentation system that the resident’s intake was less than 50% over 3 days on five separate occasions.

A record review of notes identified a note that the resident had a change in condition and their intake was low, the NP was to initiate a supplement. A nutritional supplement was not initiated until three days later.

Interviews with PSW #109 and #117 shared that they offered the resident first choice and second choice and the resident refused to eat would drink. Alternatives were peanut butter or cheese sandwiches and crackers which were not taken but that fluid alternatives for those resident feeling unwell were not available or offered.

An interview with the DDS identified that when resident's are feeling unwell in the past, with normal flu outbreak, they would could offer clear fluids, broth soup, jello, and gingerale and that they did have a policy in the home. The DDS confirmed that dietary did not receive requests for or initiate clear fluid alternatives during the April time period when resident's including resident #088 were unwell.

An interview with RPN #152 was unable to demonstrate that action was taken prior to April 26 when a supplement was added to support the resident's intake. The RPN stated that clear fluids was just on the radar with so much happening but recognized it could have been.

An interview with the DOC confirmed that they had not identified the provisions of clear fluids on the wings during their time in the home.

The nutritional care program failed to respond to the clinical alerts when the resident's intake was reported to be Less than 50% of meal intake over 3 days on two identified dates and failed to include food and fluid alternatives for unwell residents to mitigate and manage identified risk to nutritional care. [s. 68. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the nutrition care and hydration programs include the identification of any risks related to nutrition care and dietary services and hydration, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 74. Registered dietitian

Specifically failed to comply with the following:

s. 74. (2) The licensee shall ensure that a registered dietitian who is a member of the staff of the home is on site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. O. Reg. 79/10, s. 74 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Registered Dietitian (or dietitians) who is a member of staff of the home on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties.

An interview with the RD confirmed they provide Altamont Care Community with 80 hours per month on-site and it was their only LTC home. The RD confirmed they were not on-site at Altamont from April 7 until June 25, 2020.

The RD provided 17 on-site hours in April, 0 hours in May and 16 hours in June, 2020.

During the RD interview the Inspector asked if the RD was aware that residents on tray service were not receiving the required level of assistance/encouragement as a result of inadequate staffing; that mealtimes were extended resulting in meal/snack compression affecting resident's intake; that resident's were complaining that hot food was cold and their preferences/dislikes were not communicated to PSW. That fluids were not provided according to the planned menu. The RD shared that they were aware of the staffing issue but unaware of the other areas of risk to the nutrition and hydration program.

The licensee has failed to ensure that the Registered Dietitian (or dietitians) who is a member of staff of the home on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties. [s. 74. (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 the Registered Dietitian (or dietitians) who is a member of staff of the home on-site at the home for a minimum of 30 minutes per resident per month to carry out clinical and nutrition care duties, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 75. Nutrition manager

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure the Nutrition Manager (NM) worked on site in the capacity of Nutrition Manager for the minimum number of hours per week without including any hours spent fulfilling other responsibilities.

On February 21, 2020, when the home's Environmental Services Manager (ESM) position became vacant the Director of Dietary Services (DDS) /Nutrition Manager was asked to assume and agreed to fulfilling half of the ESM role for housekeeping and laundry, until a replacement was hired. The NM identified that the Food Service Supervisor worked additional hours to compensate for lack of NM's hours.

On April 1, 2020, the home's census was 153 residents. The staffing requirement of the Nutrition Manager who works on site in the capacity of Nutrition Manager would be 46 hrs per week for 153 residents.

From April 2, 2020 until May 28, 2020 the Food Service Supervisor was not working in the home and not replaced and the DDS continued working in the capacity of part time DDS and ESM until May 19, 2020 when the ESM position was temporarily filled.

An interview with the DDS shared that their hours/time in the ESM's role during the outbreak was hard to identify but maybe two hours a day or 10 hours a week was spent on ordering, payroll and team meetings for housekeeping and laundry staff. The DDS acknowledged the shortfall in NM hours during this time.

A further interview identified that the RD was not on-site from April 7 – June 25, 2020, leaving the DDS in charge of the home’s Food and Nutrition Program.

The licensee has failed to meet regulatory requirements related to the dining and snack service as outlined in this report.

The Director of Dietary Services who work on site in the capacity of Nutrition Manager worked approximately 27hrs a week between April 2 and May, 19, 2020 and despite the reduced resident census the hours failed to meet the staffing requirement for a Nutrition Manager.

The licensee failed to ensure that Nutrition Manager who work on site in the capacity of Nutrition Manager worked for the required number of hours per week without including any hours spent fulfilling other responsibilities. [s. 75. (3)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Nutrition Manager (NM) worked on site in the capacity of Nutrition Manager for the minimum number of hours per week without including any hours spent fulfilling other responsibilities, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 92. Designated lead — housekeeping, laundry, maintenance

Specifically failed to comply with the following:

s. 92. (2) The designated lead must have,
(a) a post-secondary degree or diploma; O. Reg. 79/10, s. 92 (2).
(b) knowledge of evidence-based practices and, if there are none, prevailing practices relating to housekeeping, laundry and maintenance, as applicable; and O. Reg. 79/10, s. 92 (2).
(c) a minimum of two years experience in a managerial or supervisory capacity. O. Reg. 79/10, s. 92 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the designated lead for housekeeping, laundry, and maintenance had knowledge of evidence-based practices and/or prevailing practices as applicable.

During staff interviews and environmental observations related to the shower rooms on the wings, Inspector #672 was informed by the ESM that they were a new employee of the home and had been hired for a six month contract, while the licensee searched for a permanent Environmental Services Manager. During the interview, the ESM indicated they had started working in the home on May 19, 2020, and prior to their contract, the licensee had the Nutritional Manager and Recreational Manager covering the role, on top of their regular duties. The ESM further indicated they had informed the licensee of the legislative requirements which indicated that the designated lead for the housekeeping, laundry, and maintenance departments were expected to have knowledge of evidence-

based practices and/or prevailing practices as applicable, which the Nutritional Manager and Recreational Manager did not possess.

During an interview, the Acting ADOC indicated the licensee's ESM position became vacant on February 21, 2020, and the home had been in the process of searching for a new ESM when the pandemic began. Due to the global pandemic and internal outbreak occurring in the home, the licensee had not focused on replacing the ESM role and continued with the Nutritional Manager and Recreational Manager fulfilling half of the ESM role each. The Acting ADOC indicated the Nutritional Manager and Recreational Manager were responsible for supervising and running the maintenance, housekeeping and laundry departments, including supply ordering and troubleshooting, until a replacement was hired.

During separate interviews, the Nutritional Manager and Recreational Manager indicated they had been asked to assist with supervising and running the maintenance, housekeeping and laundry departments from February 21 to May 19, 2020, when the current ESM was hired on a temporary contract. The Nutritional and Recreational Managers indicated their roles and responsibilities included tasks such as supply ordering and troubleshooting for each of the maintenance, housekeeping and laundry departments, if a problem arose. The Nutritional Manager and Recreational Manager further indicated they were not conducting any auditing or preventative maintenance related to the housekeeping, maintenance and laundry departments and did not have any previous professional experience or knowledge of evidence-based practices or prevailing practices within any of the departments.

During an interview, the Corporate Clinical Consultant indicated the licensee was aware of the legislative requirements which directed that the designated lead for the housekeeping, laundry, and maintenance departments was to have a post-secondary degree or diploma; knowledge of evidence-based practices and/or prevailing practices as applicable; and a minimum of two years experience in a managerial or supervisory capacity. The Corporate Clinical Consultant further indicated the Nutritional and Recreational Managers were only missing the knowledge of evidence-based practices and/or prevailing practices specifically related to the housekeeping, laundry, and maintenance departments but they had the option of calling someone from the corporate office to ask questions and receive direction, if they felt uncomfortable or uncertain with an issue/concern possibly occurring in the home. Lastly, the Corporate Clinical Consultant indicated they believed the ESM role would have been filled a lot sooner than it was, except the pandemic had occurred, and they didn’t have the ability at the time to

recruit and hire a new manager to fill the vacancy.

The licensee failed to ensure that between February 21 and May 19, 2020, there was a designated lead for housekeeping, laundry, and maintenance who had knowledge of evidence-based practices and/or prevailing practices as applicable. [s. 92. (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 the designated lead for housekeeping, laundry, and maintenance had knowledge of evidence-based practices and/or prevailing practices as applicable, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart which was kept secure and locked.

This IP was initiated in response to the Canadian Armed Forces (CAF) observation

report, dated May 14, 2020, outlining several concerns related to the medication administration practices in the home.

During observations made in the home between June 4 and 29, 2020, Inspector #672 observed the following:

- On June 4, 2020, at 1540 hours, Inspector #672 observed RPN #145 walk away from the medication cart, leaving it unlocked, to enter a resident's room two doors away. RPN #145 returned to the medication cart at 1551 hours, eleven minutes after leaving the medication cart unlocked and unsupervised.

- On June 10, 2020, at 1100 hours, Inspector #672 observed RPN #130 walk away from the medication cart, leaving it unlocked, to enter a resident's room across the hall. RPN #130 returned to the medication cart at 1105 hours, approximately four and a half minutes after leaving the medication cart unlocked and unsupervised and Inspector #672 was able to open every drawer of the medication cart prior to the RPN returning.

- On June 18, 2020, at 1205 hours, Inspector #672 observed RPN #152 leave the wing during a medication administration pass, leaving the medication cart unlocked. RPN #152 returned to the medication cart at 1209 hours, approximately four minutes after leaving the medication cart unlocked and unsupervised and Inspector #672 was able to open every drawer of the medication cart prior to the RPN returning.

- On June 22, 2020, at 1211 hours, Inspector #672 observed RPN #115 walk away from the medication cart, leaving it unlocked, when they entered a resident's bedroom three doors down and across the hall from where the medication cart was parked. RPN #115 returned to the medication cart at 1216 hours, approximately five minutes after leaving the medication cart unlocked and unsupervised, during which time Inspector #672 was able to open every drawer of the medication cart, prior to the RPN returning.

- On June 29, 2020, at 1615 hours, Inspector #672 observed RPN #212 leave the wing during a medication administration pass, leaving the medication cart unlocked. RPN #212 returned to the medication cart at 1621 hours, approximately six minutes after leaving the medication cart unlocked and unsupervised and Inspector #672 was able to open every drawer of the medication cart prior to the RPN returning.

During separate interviews, RPNs #145, #130, #152, #115 and #212 indicated the expectation in the home was for medication carts to always be left locked when the nurse

could not be directly in front of the cart.

During separate interviews, the Acting DOC and the Corporate Clinical Consultant indicated the expectation in the home was for medication carts to always be kept locked when the cart could not be supervised by the nurse.

The licensee failed to ensure that drugs were stored in a medication cart which was kept secure and locked on five separate occasions between June 4 and 29, 2020. [s. 129. (1) (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 drugs were stored in an area or a medication cart which was kept secure and locked, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (1) Every licensee of a long-term care home shall ensure that the Director is immediately informed, in as much detail as is possible in the circumstances, of each of the following incidents in the home, followed by the report required under subsection (4):
5. An outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

Findings/Faits saillants :

1. The licensee failed to ensure that the Director was immediately informed, in as much detail as possible, the circumstances related to an outbreak of a disease of public health significance or communicable disease as defined in the Health Protection and Promotion Act.

During a review of the outbreak critical incident report, Inspector #672 noted that on

March 25, 2020, the home was declared in an outbreak, as per the direction of the local Public Health Unit. The outbreak was declared over on June 11, 2020. Inspector #672 noted the critical incident report had not been submitted to the Director until May 31, 2020.

During an interview, the Corporate Clinical Consultant indicated IPAC lead #151 was responsible for filing the critical incident report with the Director. The Corporate Clinical Consultant further indicated the expectation in the home was for all critical incident and mandatory reports to be filed with the Director as per the legislative requirements.

During an interview, IPAC lead #151 indicated they were responsible for submitting the outbreak critical incident report to the Director. IPAC lead #151 further indicated they had not submitted the report to the Director until May 31, 2020, because they believed they had read in the Key Messages shared by the Director that critical incident reports did not need to be filed during the pandemic, unless they were directly related to allegations of resident abuse and/or neglect.

During record review, Inspector #672 reviewed the Key Messages shared by the Director, which indicated the following:

“The emergency order provides flexibility and alleviate burden on long-term care homes during the pandemic by:
Reporting
• Only mandatory reports and critical incidents to be reported to the Director”.

Inspector #672 reviewed the Key Messages shared by the Director with IPAC lead #151 and they indicated they had misread the Key Messages and when the home was declared in outbreak by Public Health March 25, 2020, they should have filed the critical incident report according to the legislative requirements.

The licensee failed to ensure that the Director was immediately informed, in as much detail as possible, regarding the outbreak declared in the home on March 25, 2020. [s. 107. (1) 5.]

Issued on this 10th day of August, 2020

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

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

Public Copy/Copie du rapport public

Name of Inspector (ID #) / Nom de l’inspecteur (No) :	DIANE BROWN (110), JENNIFER BATTEN (672)
Inspection No. / No de l’inspection :	2020_595110_0009
Log No. / No de registre :	010396-20
Type of Inspection / Genre d’inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Jul 29, 2020
Licensee / Titulaire de permis :	Vigour Limited Partnership on behalf of Vigour General Partner Inc. 302 Town Centre Blvd, Suite 300, MARKHAM, ON, L3R-0E8
LTC Home / Foyer de SLD :	Altamont Care Community 92 Island Road, SCARBOROUGH, ON, M1C-2P5
Name of Administrator / Nom de l’administratrice ou de l’administrateur :	Jane Smith

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Vigour Limited Partnership on behalf of Vigour General Partner Inc., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5. of the Long Term Care Homes Act (LTCHA).

The licensee shall ensure that the home is a safe and secure environment for its residents.

Specifically, the licensee shall:
1. Prepare, submit and implement a plan to ensure the home is a safe and secure environment for residents. The plan must include measure to be taken when critical staffing shortages are identified that impact resident safety and when basic care needs cannot be met.
2. Identify persons responsible for implementing components of the plan and timelines of implementation.

The plan is to be submitted by email to CentralEastSAO.MOH@ontario.ca referencing report # 2020_595110_0009 to Diane Brown, LTC Homes Inspector, MLTC, by August 14, 2020 and implemented by September 30, 2020.

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

Grounds / Motifs :

1. This IP was initiated In response to the Canadian Armed Forces (CAF) observation report, on an identified date, outlining a concern that only one PSW available to provide care to 40 residents.

The layout of the home was one level with four separate wings; wings 1 and 2 were known as Unit A, and wings 3 and 4 as Unit B. On an identified date an

outbreak was declared throughout the home and all wings, totaling 153 residents, were placed on isolation precautions. Each of the four wings were separated by closed fire doors.

A review of the resident death register identified 49 residents passed away at Altamont Care Community over a 31day period increasing the demand on staffing to provide end of life and post mortem care. A record review of the daily staffing roster with confirmation from staffing coordinator #210 revealed daily RPN and PSW shortages, at times with only half of the staffing compliment present at the home, during the same period.

An interview with RPN #152 who worked full time and over time in the identified month, stated the staffing levels in the home were 'horrible'. Everything was very rushed, residents exhibited behaviours, residents sustained falls, and mealtimes were very challenging. RPN #152 further indicated there were residents who were very sick, needing extra fluids for fevers, and assistance but staff had very little time to spend with them. The RPN also stated that staff were unable to provide residents continence care or assistance with repositioning as required.

RPN #152 shared that the home did not have the staff to accommodate those residents whose needs increased due to their change in health. The RPN identified resident #094 whose level of eating assistance changed when they became unwell and the home did not have the staff to support the resident. The RPN shared they would provide the resident with a supplement whenever they could but the resident lost weight because they did not have the staff to provide the level of eating assistance they required, stating the priority were those residents who needed to be fed.

The RPN revealed there were those residents who had never had a skin breakdown and acquired areas of altered skin integrity, identifying resident #016 who acquired areas of altered skin integrity because staff were unable to get the residents out of bed and reposition as required. The staff shared when the unit was short staffed, residents did not get out of bed, and resident #033 had an area of altered skin integrity that worsened. The RPN stated "I would give medications in the morning and again in the afternoon and when I went back to do their dressing they were in the same position. The staff identified that resident #079's skin condition definitely deteriorated, stating is was related to

lack of continence care and repositioning. The staff further indicated the resident became more contracted from not getting up, as the home did not have the staff.

An interview with RPN #125 who worked full time between an identified period stated that the residents who would normally be independent with feeding declined and they did not have the hands to assist them. The RPN stated they felt the residents declined quicker since they were unable to assist them with fluids and food to the degree they should have and identified resident #072 as requiring more assistance than was provided and noticed their overall intake was less. The RPN stated they would bring the resident out into the hallway so anyone passing could encourage the resident but staff were often too spread out and in rooms feeding residents.

An interview with RN #169, who worked full time shared how dramatically the home was short staffed. The RN stated that residents with an illness had no appetite. Residents needed encouragement to eat and drink but the home did not have the staff to provide the assistance. The RN revealed they had to direct staff to move on to the next resident if the resident did not want to eat as there was no time for staff to encourage a little longer, pushed a little more and offer more fluids. The focus was on the ones who were the most ill. The RN further indicated that it was not a coincidence that the residents who were still present in the home were the ones who were able to feed themselves and take their own drinks when the home did not have the staff. A review of the Weight Summary Report identified 49 residents were weighed in May 2020, and 42/49 or 86 per cent of the residents lost weight between March 2020 and May 2020.

Please refer to the following areas of non compliance identified within this report related to:
r. 50. (2) (d) Failing to provide for repositioning of resident #033. The resident experienced deterioration of a pressure ulcer resulting in significant pain.
r. 73. (1) (9) Failing to provide resident #056 the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. Resident #056 lost 8.3 kilograms of weight between two specific months. Failing to provide resident #072 mealtime assistance. The resident lost 8.4 kilograms of weight between two specific months.
r. 51. (2) (c) Failing to provide resident #003 who was unable to toilet

independently some or all of the time, the assistance from staff to manage and maintain continence. The resident self restricted their fluid intake to avoid urinating in their brief as they were not provided toileting assistance. The resident was transferred to the hospital and assessed with a specified diagnosis.

The licensee failed to provide a safe environment for residents, by not providing for resident's assessed care and safety needs when the licensee failed to ensure there were sufficient numbers of staff working in the home.

From the Daily Staffing Roster three shifts were selected and focused for review and captured as follows:

Identified shift in April 2020
A review of the staffing schedule and confirmed by staffing coordinator #210, the identified shift in April 2020 consisted of 1 RN and 3 PSWs for 133 residents. The home was short 1 RN and 1 PSW from their staffing plan.

An interview with RN #203 who worked as the only RN on the identified shift in April 2020 stated they were able to convince the prior shift RPN to stay until a specified time but felt the staffing level of 3 PSWs and 1 RN for 133 residents did not provide for a safe environment for the residents, especially after a specified time. The RN stated they were unable to monitor all residents with fevers and for respiratory distress. They were concerned about not leaving a distressed resident with another registered staff as they placed a called to the on call doctor or 911.

A record review of the home's 'Resident Death Register' identified four residents who passed away on a specified date with the specific cause of death.

There was one PSW available to provide care and safety monitoring to 44 residents the identified shift in April 2020.

The licensee has failed to provide a safe environment by not following their staffing plan with regular safety monitoring, safety checks, and medication administration as the home's staffing plan was developed to provide for a staffing mix that was consistent with residents' assessed care and safety needs.

Identified shift in April 2020
On the identified shift in April 2020, the home's census was 128 residents and the established staffing plan on a specific shift was 2 RNs, one for each unit and 4 PSWs one on each wing.

A review of the staffing schedule and as confirmed by staffing coordinator #210 on the identified shift in April 2020, consisted of 1 RN and 2 PSWs for 128 residents. The home was short 1 RN and 2 PSW from their staffing plan.

An interview with full time RN #200 who worked the identified shift in April 2020, and scheduled for the specific home area shared that when they arrived for their shift they were asked to complete a narcotic count over on another home area. The RN stated until then they were not made aware that the home was short 1 RN for a specific wing. It was after starting their shift that the RN also became aware that the home had only 2 PSWs in the home on the identified shift.

The RN stated that three residents had just passed away, the RPN on the prior shift agreed to stay overtime until a specified time, only to finish post mortem care. The RN stated that they were overwhelmed and called the on-call manager to advise of the staff shortages. The RN was requested to make staff replacement calls. The in-charge RN had the responsibility of the non-care task of calling for replacement staff. RN #200 was unable to complete this task on the identified shift in April 2020.

An interview with PSW #201 shared that they stayed in the specific wings on the above noted identified shift in April 2020 with 31 residents and their colleague looked after three other wings. The staff stated that residents on an identified wing were sick, and they tried to spend time giving them sips of fluid. The PSW shared that two residents, in particular, were at risk for falling and one resident, #175 had a fall on that specific shift. The PSW stated they were so short staffed they called 911 prior to informing the RN, as they felt the fallen resident was unwell, with a specific medical condition, not eating nor drinking, would not stay in their bed and they were unable to consistently monitor them for safety.

A record review of progress notes by RN #200 identified that resident #175 had sustained a fall at the reported time that shift. The note revealed the resident was assessed, stable, and placed into bed with multiple staff assistance. The resident was encouraged to use call bell in case of need.

An interview with RN #200 confirmed that PSW #201 had called 911, unbeknownst to them and the paramedics in turn called them to check on resident #175's status. The RN stated it was out of character for PSW #201, but they were concerned and frustrated that resident #175 had been falling the last few identified shifts and they could not consistently monitor the resident for their safety and care for all the other residents including those unwell.

An interview with PSW #202 confirmed that they were scheduled for specific wing with 27 residents on the specific shift in April 2020. However, at the beginning of their shift, RN #200 asked them to also cover other wings resulting in another 70 residents. This direction resulted in PSW #202 being responsible for the provision of care and safety monitoring of 97 residents over three home areas. The PSW stated they were originally told because of infection control reasons they were prohibited to go from one area to another, however, on the identified shift in April 2020, the home was so short staffed that RN #200 asked them to respond to any call bells, complete check and changes for continence and resident rounds for residents on three specific wings. The PSW identified that they were concerned that residents would fall while no one was present on the wings, that as soon as they heard a bell that they would run, having to change PPEs between wings, to prevent a resident from trying to self transfer when they needed toileting assistance. The PSW shared they were unable to complete safety checks and brief changes for residents on specific wings a second time during shift.

There was one PSW available to provide care and safety monitoring to 64 residents the identified shift in April 2020.

The interview with RN #200 shared that they did not feel the staffing level provided for a safe environment for residents with 2 PSWs and 1 RN being

responsible for 128 residents, including monitoring those residents very ill; the building and replacements calls for specific shift sick calls. The RN and schedule identified three sick calls requiring replacement that shift. The RN further stated they could not make proper safety rounds and monitor residents closely for respiratory distress, fever or needing oxygen and that they normally do their first round at a specific time but they were dealing with the staffing shortage and calls to the on call manager they were unable to make rounds until much later.

The RN stated that they were unable to provide the regular pain assessments and 0600hrs medications to residents at a specified time.

A record review identified that resident #025 did not receive their specific medications as ordered. The order, written in capital letters, gave specific directions for a medication administration.
Resident #045 did not receive their identified assessment and resident #015 did not receive their specific medication as ordered.

A focused review of a specific unit residents identified 12/36 residents were identified at high risk for falls on a identified shift in April 2020. The review revealed that residents were unwell; residents #092, #091 and #093 passed away on identified dates and times in April 2020.
PSW #201 interviews shared that they were split between three separate units and all residents were not monitored throughout the shift.

Identified shift in April 2020
A review of the staffing schedule and as confirmed by staffing coordinator #210 the identified shift in April 2020, consisted 8 PSWs, 1 RN, 3 RPNs instead for 128 residents. The home was short staffed by 1 RN, 2 RPNs and 8 PSW from their staffing plan.

An interview with RPN #125 revealed that when they arrived to work for their identified shift in April 2020, they were told that they were short 1 RPN and 1 RN and this would result in them being responsible to administer all medications from three medication carts on two wings for 79 residents until someone else could arrive. The RPN stated this was their first nursing job and had only worked a few casual shifts. The RPN stated that they were unable to provide resident

#095 with their specifically scheduled medication order. The RPN stated it was not administered until after the resident's meal by their colleague RPN #156 who came over from another wing to help. RPN #125 stated the resident's specific medical treatment was normally well controlled and stable, and identified another resident whose specific medical treatment were negatively affected because of the lack of regular scheduled medication administration.

A record review of the resident's, eMAR on an identified date in April 2020, indicated the medication was to be administered at a specific time with identified parameters.

The licensee failed to ensure a safe and secure environment for the residents during a specific time in April 2020. Registered staff and personal support workers were left to work with unsafe staffing levels resulting in residents not receiving basic care, medication management and treatments. [s. 5.]

The severity of this non-compliance is determined to be actual harm as the residents were impacted by worsening conditions and not receiving care for several hours. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous related areas of noncompliance noted in the home related to s. 5., which included a VPC issued in a Critical Incident Report Inspection #2019_616722_0018, in October 2019. (110)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 20. (2) The licensee shall ensure that, if central air conditioning is not available in the home, the home has at least one separate designated cooling area for every 40 residents. O. Reg. 79/10, s. 20 (2).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 20. (2).

The licensee shall ensure that when central air conditioning was not available in the home, there was at least one separate designated cooling area available for every 40 residents.

Specifically, the licensee shall ensure there is at least one separate designated cooling area available for every 40 residents.

Grounds / Motifs :

1. The licensee has failed to ensure that when central air conditioning was not available in the home, there was at least one separate designated cooling area available for every 40 residents.

During resident interviews conducted in June 2020 multiple residents complained to Inspector #672 that they were frustrated and uncomfortable on the wings due to feeling very hot and sweaty, as a result of the fire doors at the entrance of the wings being closed, which did not allow for air circulation, and not being allowed to open their windows or run any fans or air conditioning units. The residents indicated they were not allowed to leave the wings without being accompanied by a staff member, which could only be scheduled when a staff member was available. The residents further indicated when they were able to find a staff member available to take them off the wings, they were only allowed to leave the wing and immediately go outside onto the property and gardens but could not go anywhere else within the facility. According to the residents, this was often not a refreshing alternative to escape from the high temperatures and humidity experienced inside the wings due to the high heat and humidity outside

as well.

Inspector #672 toured the home and observed that three resident wings had designated cooling stations for staff members available just outside of each wing, and one wing had a cooling station available for staff members within the wing as it had previously been a resident bedroom. Between June 16 and 30, 2020, Inspector #672 spent several hours per day on a specific in June 2020, and did not observe any residents being brought into the cooling station on the wing to attempt to cool them down. The designated cooling stations for staff members for specific wings and Inspector #672 did not observe any residents being brought into either of the cooling stations at any time. Inspector #672 also attempted to observe the temperatures and humidex on each of the wings, but no thermometers or hygrometers were available except on one unit. On a specified date in June 2020, Inspector #672 found a thermometer on an identified unit which read 89 degrees. There was no hygrometer available to indicate the humidex reading on the unit.

During separate interviews, PSWs #108, #110, #116, #117 and #185 and RPNs #115 and #130 indicated they were not aware of any thermometers or hygrometers available on the wing to read the temperatures and humidex. PSWs #110 and #116 indicated the equipment used to be present on an identified wing but it had been missing "for a while now."

During separate interviews, PSWs #108, #110, #116, #117, #120, #121, #127, #132, #174 and #185, RPNs #115, #130 and #145 indicated residents were not allowed to leave the units at all without staff escorts, to ensure they did not wander throughout the facility and possibly spread germs to other areas. The staff further indicated that when staff members were available, a resident could request to be escorted outside for short periods of time, but they had to immediately go from the wing straight outside. PSWs #108, #110, #116, #117, #120, #121, #127, #132, #174 and #185, RPNs #115, #130 and #145 further indicated they were aware of cooling stations available in the home for staff members, as the cooling stations were being utilized as break rooms for the staff from each wing to attempt to ensure staff followed infection control prevention protocols. The staff further indicated they were not aware of cooling stations in the home available for residents to lounge in, to assist in cooling the residents and escaping the high temperatures and humidity felt on the wing. Lastly, the

staff indicated no fans or air conditioning units were currently available in the home for residents to use, the wings frequently became very hot and humid throughout the day and staff were not completing any additional nourishment rounds to offer additional fluids to residents but would provide fluids to residents at any time they asked for them.

During an interview, Environmental Services Worker (ESW) #133 indicated they were aware of cooling stations available in the home for staff members, but not for the residents to utilize.

During an interview, the Corporate Clinical Consultant indicated each of the wings were supposed to have thermometers and hygrometers available for staff to be able to read the temperatures and humidity experienced on each of the areas. The Corporate Clinical Consultant indicated the temperature on an identified wing was known to be higher than the other areas in the home due to the specific services being present on that unit, and the door to the service room should be kept closed, to assist in preventing the hot air from circulating onto the wing, but was aware that staff always had that door propped open, as the service room became too hot with keeping the door closed. The Corporate Clinical Consultant further indicated they were aware of the legislative requirements which indicated that when central air conditioning was not available in the home, there was expected to be at least one separate designated cooling area available for every 40 residents, but due to the flood on unit one and the current situation in the home, this had not been on the radar for the team to address. The Corporate Clinical Consultant indicated that staff could bring a resident into one of the designated staff cooling areas, if the staff were worried about the resident due to the temperature on the wing, but was not aware of any communication or direction which had been provided to the staff which indicated that.

The licensee failed to ensure that when central air conditioning was not available in the home due to infection control concerns, there was at least one separate designated cooling area available for every 40 residents. [s. 20. (2)]

The severity of this non-compliance is determined to be actual risk to the residents with residents at risk of heat related illness or heat intolerance being identified in the home. The scope of this non-compliance was noted to be wide

spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home.
(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 17, 2020

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:

1. Customary routines.
2. Cognition ability.
3. Communication abilities, including hearing and language.
4. Vision.
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.
6. Psychological well-being.
7. Physical functioning, and the type and level of assistance that is required relating to activities of daily living, including hygiene and grooming.
8. Continence, including bladder and bowel elimination.
9. Disease diagnosis.
10. Health conditions, including allergies, pain, risk of falls and other special needs.
11. Seasonal risk relating to hot weather.
12. Dental and oral status, including oral hygiene.
13. Nutritional status, including height, weight and any risks relating to nutrition care.
14. Hydration status and any risks relating to hydration.
15. Skin condition, including altered skin integrity and foot conditions.
16. Activity patterns and pursuits.
17. Drugs and treatments.
18. Special treatments and interventions.
19. Safety risks.
20. Nausea and vomiting.
21. Sleep patterns and preferences.
22. Cultural, spiritual and religious preferences and age-related needs and preferences.
23. Potential for discharge. O. Reg. 79/10, s. 26 (3).

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 :

The licensee shall be compliant with O. Reg. 79/10, s. 26. (3) 14.

The licensee shall ensure that the plan of care was based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration.

Specifically, the licensee shall:
a. Ensure that the plan of care was based on an interdisciplinary assessment of the resident's hydration status and any risks related to hydration
b. Educate all registered and front line staff on the inclusion of hydration/hydration risk on each residents plan of care and their role.
c. Retain a copy of the education and staff signatures for review by an Inspector.

Grounds / Motifs :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home completes a nutritional assessment whenever there was a significant change in the resident's health condition and assesses the resident's hydration status, and any related risks to their hydration.

Resident #033

A record review of resident #033's health record identified that on a specified date in January 2020, the RD responded to a dietary referral to assess the resident's recurring skin condition. The note identified the resident consumed 10 servings of fluid, on average, per day, 125ml/serving or 1250mls. The documentation failed to include an assessment of the resident's estimated hydration needs as compared to the resident's average fluid intake of 10 servings.

A review of the home's policy entitled 'Nutrition/Hydration Risk Identification Tool', dated March 2019, identified a resident at moderate hydration risk when they are at poor or changed fluid intake defined as less than 75% but greater than 51% of their daily fluid requirement.

Resident #033's average intake of 10 servings per day, documented on that specified date in January 2020, would be 55% (less than 75% but greater than 51%) of their daily fluid requirement of 2283mls representing a hydration risk,

that had not been assessed by the RD.

An interview with the RD identified that altered skin integrity impacts a resident's hydration needs and is a risk factor to their hydration status as adequate fluid intake plays a role in promoting healing of certain skin conditions. The RD revealed that they calculate a resident's fluid requirement higher and higher still depending on the certain skin condition.

A further record review identified documentation on a specified date in April 2020, by the RD in response to another referral flagging resident's deteriorating skin condition. The RD's documentation identified that the resident's food and fluid intake had declined but failed to include a hydration assessment.

An interview with the RD acknowledged the lack of a hydration assessment at the specified date in April 2020 referral.

On a later specified date in April 2020, a further deterioration of the skin condition was noted and generating another dietary referral. [s. 26. (4) (a),s. 26. (4) (b)]

(110)

2. Resident #018

On May 1, 2020 the RD determined resident #018 to be at high nutritional risk related to their specific medical issue and skin conditions and low intake.

Resident #018's health record identified that the resident had a significant weight loss over a two month period.
On specified date in June 2020, a RD assessment was completed, in response to a skin impairment referral. The RD documentation identified that the resident consumed 5-8 servings of fluid or 625ml -1000ml per day. No documentation assessing the resident's fluid requirement, any shortfall in fluid intake or a hydration assessment was included

On a later specified date in June 2020 and RD assessment was complete in

response to a referral that the resident's weight was below their goal weight range and decreased intake. The assessment note revealed what interventions were in place with no new approaches required.

Observations of resident #018 by Inspector #110 were conducted on specified dates in June 2020, at specific meals. The resident was not provided their level of mealtime staff assistance according to their plan of care. The resident's intake was poor.

Observations of resident #018 on another specified date in June 2020, identified their hot meal was served late, cold and the risk of influencing the desirability of the food and resident's intake.

An interview with the RD confirmed that lack of mealtime assistance, unpalatable food temperatures and skin condition were risk factors to a resident's nutrition and hydration status. The RD confirmed that these risk factors were not considered or assessed at the June 2020, referral assessments.

(110)

3. Resident #062

A record review of resident #062's health record identified a date in January 2020, where the resident was assessed and identified with altered skin integrity. The form included a check mark beside 'nutrition or hydration intervention to manage skin problems.

A review of the resident's written plan of care in place on specified date in March 2020, identified the resident at moderate nutritional risk related to an identified body mass index, specific medical issue and skin conditions The resident received a specific textured diet with modified fluid consistency and required assistance by staff with food and fluid intake.

An interview with the RD identified that altered skin integrity increases a

resident's hydration needs and that adequate fluid intake played a role in the healing of skin. The RD identified that a modified fluid consistency and the resident's specific medical conditions along with a dependence on staff for eating were considered a risk factors to a resident's hydration status.

On a specified date in March 2020, resident #062's health record identified a RD assessment that included acknowledgement of resident's areas of altered skin integrity. The noted stated the resident was drinking greater than 1500mls. The note also included reference to the resident's estimated fluid needs of 2330 ml/day but there was no assessment of the resident's hydration status.

A review of the resident's fluid intake monitored in the point click care (PCC) 'Look Back Report' on specific dates between March – April 2020 identified the resident met their estimated fluid intake on 5/35 occasions.

On specified date in April 2020, the RD reassessed the resident's fluid requirement and increased the resident's requirement to 2340-2630 ml/day in response to a worsening skin conditions referral assessment . The RD identified that the resident's fluid consumption was on average 1625ml per day. A hydration assessment was not documented.

The resident's record identified the resident with a specific clinical issue on specified dates in April and May 2020, increasing the resident's need for fluids. The resident presented with a medical condition on a specified date May 2020 and a physician note identifying the resident's deteriorating skin conditions on a specified date May 2020.

An interview with the RD acknowledged the lack of a hydration assessment on specified dates in March and April 2020, when the resident's fluid intake consistently did not meet their estimated fluid needs.

(110)

4. Resident #061

A record review identified resident #061 with had dehydration trigger during an

identified assessment in April 2020, and previously during a specific date in January 2020. On both occasions the plan of care lacked an interdisciplinary assessment of the resident's hydration status.

During separate interviews both the RD and DOC confirmed the resident's plan of care was not based on the resident's hydration status and their identified risks The RD confirmed that hydration status and risks to a resident's hydration were not identified in the resident's care plan and that it has not been the practice in the home.

Resident #097

A record review of resident #097's health record identified a hydration assessment at the time of the resident's admission on a specified date in August 2018. The assessment identified the resident required an estimated 2250mls of fluid per day.

On a specified date in December 2020, a RD note stated the resident consumed greater than 1500ml per day, with no hydration assessment or reference to their estimated fluid needs of 2250mls.

A record review of the Look Back Report for fluid intake in March 2020 - April 2020 revealed the resident seldom consumed the 2250hrs per day. From specified dates in April, 2020, the resident had an identified clinical issue that would impact the resident's hydration needs. Between specified dates in April 2020, the resident's fluid intake was reported as 500ml -750mls per day. On a specified date in April 2020, NP #149 documented for staff to continue to monitor resident and encourage intake of fluids to prevent dehydration.

On a specified date in May 2020, the RD documented an assessment that identified the resident 'drinks fair'. The documentation failed to identify a hydration assessment or interventions to address the resident's fair intake.

On a specified date in May 2020, the resident was identified with a specific medical issue and days later placed on specific intervention for fluid rehydration.

An interview with the RD acknowledged the lack of a hydration assessment when the resident's fluid intake was reported as greater than 1500ml per day on specified date December 2019 and when determined to be 'fair' on a specific date in May, 2020.

The licensee failed to ensure that the registered dietitian who is a member of the staff of the home completes an assessment of the resident's hydration status, and any risks related to hydration.

The severity of this non-compliance is determined to be minimal harm/risk to the residents. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

The licensee shall ensure that every resident is bathed, by the method of his or her choice, at a minimum of twice per week.

Specifically, the licensee shall:

a. Ensure both registered and non-registered nursing staff taken action when a bath/shower is not provided as scheduled to ensure that residents are offered another bathing option that is agreeable to them, before their next scheduled bath/shower.
b. Ensure each resident is offered a tub bath as a bathing option.
c. Ensure all showers/baths are documented as given, refused or rescheduled. All rescheduled baths shall be documented as to when they are given and by what bathing method.

Grounds / Motifs :

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

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report, dated May 14, 2020, outlining concerns related to the personal support services for residents in the home. Specifically, the report identified that at time of arrival many of the residents had been bed bound for several weeks, with no evidence of residents being moved to wheelchair for

parts of day, repositioned in bed, or washed properly. The report outlined the current staff to resident ratio at the home does not allow for more care than the most basic daily requirements that residents are changed and fed, however there was no ability to provide nail care, skin care, repositioning nor adequate wound care.

During resident interviews between specified dates in May and June 2020, Inspector #672 received complaints from multiple residents that residents were not able to shower or have a tub bath in the home, which had began at the beginning of the outbreak, around the middle of March. As a result, residents were to receive full bed-baths on their bath/shower day, but the residents indicated they had not been receiving this service a minimum of twice per week since the bathing rooms were closed to residents. The resident complainants further indicated that when bed-baths were provided, they did not always include washing the hair, nail care or foot care.

During an interview on June 3, 2020, the Acting DOC indicated the expectation in the home was for residents to receive a bed-bath at a minimum of twice weekly, in place of the resident's regular bath/shower, as the home was not currently utilizing the bath/shower rooms, due to IPAC concerns. The Acting DOC further indicated the licensee had provided "waterless bath-in-a-bag" products for staff to utilize during the resident's bed-bath, which was to include washing the resident's hair and finger and toe nail care. Lastly, the Acting DOC indicated the licensee would begin using the shower rooms again as soon as permission was received by the Public Health Unit.

During separate interviews, residents #007, #008, #022, #032, #051, #055, #067 and #080 indicated they had complained to staff several times about their personal hygiene support and fingernail care to be lacking in the home and had requested assistance, but had not received the level of assistance required "for a long time". Several residents also indicated that prior to the pandemic, they were only ever offered the option of having a shower, despite repeated requests to have a bath instead.

During resident observations made between specified dates in May and June 2020, , Inspector #672 observed the following:

- Day 1- residents #006, #017, #018, #020, #021, #022, #062 and #072 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 2 - residents #020, #026 and #027 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 3 - residents #006, #008, #010, #014, #017, #020, #021, #022, #026, #027, #029, #030, #031, #036, #038, #051, #052, #053, #054, #055, #056, #057, #058, #059 and #060 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 4 - residents #009, #011, #012, #018, #027, #030, #062, #066, #067 and #077 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 5 - residents #009, #015, #021, #027, #030, #062 and #063 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 6 - residents #020, #022, #024, #027, #029 and #075 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 7 - residents #015, #064, #086 and #087 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 8 - residents #015, #064 and #077 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 9 - residents #015, #020, #021 and #062 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 10 - residents #062 and #077 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

- Day 11 - residents #026, #027, #044, #062, #077 and #080 were noted to have unkempt appearances which included greasy/unbrushed hair, long facial hair, dirt/grim and dry skin between the fingers and toes, dirty hands, debris around the outside of eyes and mouths, dirty/stained clothing and/or wheelchairs and dirty feet.

During separate interviews, PSWs #110, #116, #117, #108, #132 and #174 indicated that they did not utilize the waterless bathing products supplied by the licensee, as they found that the products "left a greasy film" on the residents and "made the residents look and feel dirty", which had been reported to the Acting DOC and Acting ADOC. The PSW staff further indicated that full bed-baths were supplied to the residents "depending on time" and often did not include washing the residents hair, due to the concerns with the bathing products being

supplied.

On May 29, 2020, the home received an IPAC assessment completed by the Regional IPAC Specialist from Public Health Ontario, which was attended by Inspectors #110 and #672, along with the Acting DOC and Acting ADOC. During this assessment, the IPAC lead indicated it was an acceptable practice for the licensee to utilize the shower rooms for resident bathing/showers, as long as appropriate PPE was worn by staff and the rooms were cleaned after each usage.

On June 2, 2020, the Regional IPAC Specialist from Public Health Ontario provided a written report to the licensee, entitled "Post-Visit Recommendations for COVID-19 Preparedness" which indicated the following:

"6. Bathing and Hair Care: Residents are being bathed with warmed bathing wipes. Discussed that there is no restriction on bathing in tub or shower, with appropriate PPE and cleaning/disinfection between residents. There is a hair dressing salon and the sink there could be used with care to wash resident's hair with similar cleaning protocols between residents."

During separate interviews on June 22, 2020, residents #007, #008 and #040 indicated they still had not received any bathing/showers in the shower room and were only receiving bed-baths which did not include washing the resident's hair.

On June 22, 2020, Inspector #672 observed the shower rooms on all units of the and observed the rooms appeared to be unsanitary, with dirt, grime and dust over the floors, tubs and equipment, with pools of stagnant water on areas of the floors and around drains. The tub on unit two was observed to be broken with yellow caution tape wrapped around it.

During separate interviews, PSWs #156, #177, #181, #190 and #191 indicated the bath tub on unit two had been broken prior to the pandemic and were unsure of when it would be fixed.

During an interview on June 22, 2020, the Corporate Clinical Consultant indicated the licensee was awaiting permission from the Centenary Health team,

who was managing the home, to be able to utilize the shower rooms for resident's bath/showers. The Corporate Clinical Consultant further indicated they were aware the bath tub on unit two had been broken prior to the outbreak and the ESM was working on having it replaced. Lastly, the Corporate Clinical Consultant indicated the expectation in the home was for residents to receive a bed-bath at a minimum of twice weekly, in place of the resident's regular bath/shower.

During an interview on June 22, 2020, the ESM indicated they were aware the bath tub on unit two had been broken prior to the outbreak and was working on having it replaced "within the next two weeks".

During an interview on June 22, 2020, the Environmental Manager from the Centenary Health team (EMCH) indicated the licensee was unable to utilize the shower rooms to complete resident bath/showers due to the cleanliness of the rooms. The EMCH further indicated that the licensee had informed them that the shower rooms had been cleaned and were ready for usage, but upon inspection the rooms were not at an acceptable sanitary standard, therefore they were bringing in their own environmental service team to have the rooms cleaned over the following days.

During separate interviews in late June 2020, residents #007, #008 and #040 indicated they still had not received any bathing/showers in the shower room and were only receiving bed-baths which did not include washing the resident's hair.

During an interview on June 29, 2020, the Corporate Clinical Consultant indicated the licensee was beginning to utilize the shower rooms for resident bathing but were "taking things slowly to get the staff back into their usual routines because of all of the changes and everything that has happened. We are introducing things back one task at a time". The Corporate Clinical Consultant verified that the home was fully staffed with their regular staff members plus had additional staffing support daily through a contract with a staffing agency and also had approximately half of the usual resident census in the home.

On an identified date in June, Inspector #672 interviewed residents on each of

the wings in the home and asked if the residents preferred a bath or shower; if they had informed staff of their preference or were asked what their preferences were and if they received their preferred bathing option. Residents #007, #010, #014, #024, #028, #036, #038, #040, #047, #053, #057, #064, #072, #080, #081, #082 and #083 all indicated they preferred having a tub bath instead of a shower and had informed staff of their preference but were only offered a shower or a bed bath as an option. The residents indicated they had been informed this was due to a tub not being available in the wing they resided on.

During separate interviews, PSWs #201 and #203 indicated if a resident was totally dependent for bathing assistance, they were always provided a bed bath or a shower, but never offered a tub bath as an option for the resident, as they felt the bed bath or showers were a safer option for the resident.

During separate interviews, PSWs #117, #173, #174, #190 and #200 indicated residents on unit one were only ever offered the option of a bed-bath or shower, as the wing only had a shower available and they never took residents off of the wing to provide their bathing preference. PSW #190 further indicated that they felt the bathtub available in wing two, although currently broken, was an unsafe option for residents who did not have "100% control of their entire body" due to staff having to raise residents so high in the air to get them over the lip of the bathtub, and therefore they did not use the tub when working on unit two either.

During separate interviews, PSWs #108, #120, #127 and #132 indicated residents on unit four were only ever offered the option of a shower, as the unit only had a shower available and they never took residents off of the unit to provide their bathing preference.

During separate interviews, PSWs #110, #116, #124, #135 and #202 indicated that although unit three had a bathtub available for residents, they never utilized the tub for residents to soak in the water. The PSWs indicated they would transfer the residents into the tub and then use the handheld shower to wash the residents, as there was not an actual shower stall available on the unit but filling the tub and allowing the resident to soak in the water "took too much time".

During separate interviews, PSWs #109, #204 and #216 indicated they would ask the residents whether they preferred a bath or shower and would then take

the resident to whichever unit had the amenities available to meet the resident's preference.

During separate interviews, the Acting DOC, Acting ADOC, DOC, ADOC #137 and the Corporate Clinical Consultant indicated the expectation in the home was for residents to be provided a full bed-bath at a minimum of twice weekly on the resident's bath/shower day, which was to include all personal hygiene services, including washing the resident's hair and nail care. The DOC, ADOC #137 and the Corporate Clinical Consultant further indicated the expectation in the home was for residents to be asked what their bathing preferences were in relation to having a bath or a shower and to be taken to another wing, if need be, in order to meet the resident's needs and/or preferences.

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

The severity of this non-compliance is determined to be minimal harm/risk to the residents. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous related areas of noncompliance noted in the home related to s. 33., which included a VPC issued in a Complaint Inspection #2019_486653_0013, in June 2019. (672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 005

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 229. (4).

The licensee shall ensure that all staff participate in the implementation of the program.

Specifically, the licensee must:

1) Retrain all staff on proper hand hygiene practices, donning and doffing of PPE, physical distancing requirements of residents and staff and proper placement of PPE stations. A documented record is to be kept of the training of all staff.
2) Develop and implement a monitoring process to ensure compliance of all staff with the IPAC program, including practices of proper hand hygiene, physical distancing of residents and staff, both inside and outside of the home, and proper donning/doffing of PPE. A documented record must be kept.
3) Conduct weekly audits for a three month period of time to observe the staff are compliant with the IPAC program, including practices of proper hand hygiene, physical distancing of residents and staff, both inside and outside of the home, and proper donning/doffing of PPE. A documented record must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that staff in the long term care home participated in the implementation of the infection prevention and control program.

This Inspection Protocol (IP) was initiated based on the CAF's observation report, dated May 14, 2020, of standards of practice issues and poor infection prevention and control (IPAC).

Inspector #672 made the following observations related to infection prevention and control practices in the home between May 21 and June 30, 2020:

Related to hand hygiene:

• Between May 21 and June 11, 2020, multiple staff members were observed to be pushing resident's wheelchairs in hallways while wearing PPE which included gowns and gloves, but did not change their PPE or complete hand hygiene after they assisted the residents.

• Between June 11 and 30, 2020, multiple staff members were observed to assist residents with personal and/or continence care and were not observed to complete hand hygiene following the resident assistance.

• Between May 21 and June 11, 2020, there were multiple incidents observed of staff members assisting an unwell resident or interacting with an unwell resident's environment without changing PPE or conducting hand hygiene and then go on to assist another resident.

• Between May 21 and June 21, 2020, there were multiple observed incidents of staff members using hand sanitizer on gloves, instead of changing the gloves and/or performing hand hygiene.

• Between May 21 and June 30, 2020, Inspector #672 observed parts of several medication administration passes and did not observe hand hygiene being completed between residents, when staff were observed assisting the resident in some way i.e. taking the cup of water back from the resident or administering puffers or eye drops.

• Between May 21 and June 30, 2020, Inspector #672 observed multiple nourishment services in the mornings and/or afternoons and did not observe hand hygiene being offered or provided to residents prior to ingesting morning/afternoon nourishment.

• Between May 21 and June 30, 2020, Inspector #672 observed multiple meal services for both lunch and dinner meals and did not observe hand hygiene

being offered or provided to residents prior to ingesting meals.

Related to Personal Protective Equipment (PPE):

• Between May 21 and June 11, 2020, there were multiple incidents of PPE not being readily available close to both unwell and not sick resident's bedrooms, for staff to utilize.

• Between May 21 and June 11, 2020, multiple staff members were observed to be assisting residents with personal and/or continence care while wearing PPE which included gowns and gloves and were not observed to change their PPE after they assisted the residents.

• Between May 21 and June 11, 2020, there were multiple incidents of staff members not donning/doffing PPE appropriately, or disposing of the PPE properly.

• Between May 21 and June 11, 2020, there were multiple incidents when staff members were observed not wearing PPE appropriately, such as wearing multiple masks at the same time or having several pairs of gloves on.

• Between May 21 and June 30, 2020, there were multiple incidents when environmental staff members were observed to be interacting with both unwell and not sick resident's environments without changing PPE and/or conducting hand hygiene between each resident/resident's environment.

• Between May 21 and June 5, 2020, there were multiple observed incidents of staff members outside of the home on the grounds and parking lot, in full PPE which included gowns and gloves, and then entering the home without changing the PPE. While the staff were outside on breaks, there was no physical distancing observed and staff would often be observed standing in small groups interacting or watching something on a telephone screen.

Related to Physical Distancing:

• Between May 21 and June 11, 2020, both unwell and well residents were observed to be cohorted together in the same bedrooms, while there were

empty bedrooms available within other unoccupied resident home areas within the home.

• Between May 21 and June 30, 2020, staff were not observed implementing physical distancing practices on the resident home areas, for any of the residents. Residents were found congregating in groups at the end of the hallways, looking out the windows or watching the television.

• Between May 21 and 28, 2020, there were several incidents of staff being observed sitting on unwell resident's beds or in their wheelchairs while assisting the resident with food/fluid intake.

During separate interviews, PSWs #101, #106, #107, #127 and #132 indicated they utilized hand sanitizer on gloves during nourishment service and following assisting residents with personal care instead of changing gloves between assisting residents, as they felt it would utilize "too many gloves" if they changed them every time and/or assisted in saving time.

During separate interviews, PSWs #101, #106, #108, #127, #146, #171, #174, #188, ESA #133, RPN #130 and PTA #102 indicated they preferred to wear double masks, multiple pairs of gloves or several gowns at a time as it made them "feel more comfortable", "feel safer" or "help save time". PSWs #101, #106, #108, #127, #146, #171, #188, ESA #133, RPN #130 and PTA #102 further indicated they had received education and training related to the proper usage of PPE in the home.

During separate interviews, PSWs #108, #109, #110, #116, #117, #120, #121, #124, #127, #131, #132, #135, #139, #173, #174, #176, #177, #178, #181, #182, #191, #192, #200, #203, #204, #214, #216, #231, ESAs #133 and #207 and PTA #102 indicated the expectation in the home was for PPE to be changed between assisting each resident with personal care and hand hygiene was to be completed prior to and following assisting a resident with eating, at the beginning and end of each nourishment pass, after assisting a resident with personal care and after interacting with a resident's environment or belongings, such as pushing a wheelchair.

During separate interviews, PSWs #101, #108, #109, #110, #116, #117, #120,

#121, #174 and #200 indicated the expectation in the home was for residents to receive hand hygiene prior to ingesting each meal or nourishment.

During separate interviews, PSWs #185, #191, #202, #213, #214 and #224 indicated residents did not require hand hygiene to be performed prior to ingesting each meal or nourishment, as "the resident should have received hand hygiene during personal care" and "residents don't go anywhere to get dirty".

During separate interviews, PSWs #101, #108, #109, #110, #116, #117, #120, #121, #131, #174 and #200 indicated the expectation in the home was for physical distancing between residents to be maintained, but "it was too hard" to ensure residents maintained physical distancing in the home, related to limited spaces for the residents to congregate on the resident wings and some residents experiencing responsive behaviours and/or dementia.

During separate interviews, PSWs #124, #132, #135, #146, #171, #173, #176, #177, #181, #185, #188, #191, #192 and #213 indicated the expectation in the home related to physical distancing between residents was that residents were to be kept on their resident wing to prevent interaction between the units in the home, but if the resident remained on the wing, they could congregate wherever they liked.

During separate interviews, RPNs #114, #115, #130, #145, #212 and RN #215 indicated the expectation in the home was for hand hygiene to be completed prior to and following administering medications to each resident, if they touched or assisted the resident or the resident's environment in any way.

During an interview, the Acting ADOC indicated the expectation in the home was for unwell and well residents to be cohorted in separate bedrooms. The Acting ADOC further indicated the expectation in the home related to hand hygiene was for staff to perform hand hygiene and/or change PPE after every physical interaction with a resident or the resident's environment and hand hygiene was to be completed for every resident prior to consuming any food/fluids. Lastly, the Acting ADOC indicated it was never an accepted practice in the home to use hand sanitizer on a pair of gloves instead of performing hand hygiene or changing the gloves; to not wear PPE as directed, which included wearing multiple sets of PPE; and all staff members had received education regarding

how to properly don/doff PPE.

During separate interviews, the Acting DOC, Corporate Clinical Consultant and ADOC #137 indicated the expectation in the home related to hand hygiene was for staff to perform hand hygiene and/or change PPE after every physical interaction with a resident or the resident's environment, which included during medication administration, and hand hygiene was to be completed for every resident prior to consuming any food/fluids. The Acting DOC, Corporate Clinical Consultant and ADOC #137 further indicated the expectation in the home was for physical distancing between residents to be maintained, where possible, both on and off the wings. Lastly, the Acting DOC, Corporate Clinical Consultant and ADOC #137 indicated it was never an accepted practice in the home to use hand sanitizer on a pair of gloves instead of performing hand hygiene or changing the gloves; to not wear PPE as directed, which included wearing multiple sets of PPE; and all staff members had received education regarding how to properly don/doff PPE.

The licensee failed to ensure that staff participated in the implementation of the infection prevention and control program during the pandemic between May 21 and June 30, 2020 when the Inspector was on-site.

The severity of this non-compliance is determined to be actual harm, as the residents experienced worsening conditions and poor control of the outbreak. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous related areas of noncompliance noted in the home related to r. 229 (4), which included a Voluntary Plan of Compliance issued in a Resident Quality Inspection #2018_414110_0013 served in February 2019 and another Voluntary Plan of Compliance issued in a Critical Incident Report Inspection #2019_616722_0018, in October 2019.
(672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 006

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 73. (1) 5.

The licensee shall ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

Specifically, the licensee shall:
a. Ensure that information is obtained on all resident's special needs and preferences related their nutrition and hydration.
b. Ensure the resident information obtained is part of a system to communicate residents' diets, special needs and preferences to food service workers and other staff assisting residents at meals an snacks.
c. Educate all direct care staff on this order, related grounds and the home's plan of corrective action.

Grounds / Motifs :

1. The licensee has failed to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.

On March 31, 2020, the home was placed on isolation precaution, dining room service was suspended and tray service began.

From March 31, 2020 until May 18, 2020 tray service was accompanied to the wings with a resident diet sheet referencing the resident's name, room number, diet, diet texture and fluid consistency. The system failed to include resident's special needs and preferences.

A record review of resident #003s health record identified a note by nurse practitioner #149 on an identified date, that the resident had a change in condition and for staff to encourage fluid intake. The resident's RD admission assessment documented the resident's fluid preferences.

During separate interview with PSW #127, PSW #235 and PSW #108 the resident's fluid preferences were inconsistent and not in keeping with the RD's documentation.

An interview with resident #063 and #051 separately identified they loved milk

but were not receiving it at meals and snacks.

An interview with an agency PSW #232 shared there was no process in place to guide agency staff in offering residents their preferred fluids and a staff would not know who preferred milk or their preferences. The PSW shared there was only a resident list with the resident's name, room number, diet, diet texture and fluid consistency.

An interview with dietary aide's #239 and #238 confirmed a system was not in place to ensure dietary staff portioning residents food on tray service were aware of resident's special needs and preferences. The staff shared that military staff would come into the kitchen and ask staff if a resident could have milk and also gave dietary staff a list of residents who did not like eggs.

Dietary aide #239 shared that resident #087 will not eat anything with gravy. Dietary aide #238 confirmed that as a food service workers plating resident #087's meal they would not be aware of their preference for 'no gravy' when preparing their meal tray.

A record review of resident #024's health record identified the resident required for straw for all fluids.

Dietary aide's #239 and #238 expressed an unawareness of the resident's need for straws for when setting up the resident's meal tray. They confirmed there was no process in place to ensure that food service workers and other staff assisting residents were aware of the resident #024 need for straws.

An interview with military personnel identified there was no system in place at mealtimes to identify resident's dietary special needs and preferences. An interview with PSW #101 confirmed same.

The resident's continued on tray service until at least June 30, 2020, when Inspectors left the home, representing a three month period of time.

An interview with RD #217 confirmed a process was not in place to communicate to PSW staff, assisting residents on the wings, a resident's preferences.

The severity of this non-compliance is determined to be actual harm, as some residents experienced significant weight loss. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 50. (2).

The licensee shall ensure that the resident who is dependent on staff for repositioning been repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

Specifically, the licensee must:

1) Develop and implement a system to ensure residents who are dependent on staff for repositioning are being repositioned at a minimum of every two hours, or more often, according to the resident's needs. A documented record must be kept.
2) Educate the PSW and Registered staff members on the internal policy related to the repositioning requirements in the home and ensure the education includes direction related to the residents receiving repositioning while in a bed or chair. A documented record must be kept.
3) Conduct an audit to ensure that every resident in the home who requires a repositioning clock has one posted in their bedroom space. A documented record must be kept.
4) Conduct an audit to ensure that every resident in the home who is dependent on staff for repositioning has a task related to repositioning entered in the Point of Care (POC) documentation system. A documented record must be kept.
5) Conduct weekly audits for a three month period of time to observe the residents who are dependent on staff for repositioning are being repositioned at a minimum of every two hours. A documented record must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident who is dependent on staff for repositioning was repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

This Inspection Protocol (IP) was initiated based on the CAF's observation report, dated May 2020, outlining a lack of repositioning and prolonged bed rest resulting in deteriorating skin conditions. Military arrived in the home on identified date in April 2020.

Ministry Inspectors arrived on site on May 21, 2020. Inspector #672 identified that residents remained in bed for the duration of the day and on subsequent identified dates in May and June 2020 days, upon further observations.

Resident #033.

Resident #033's written plan of care identified that two team members are to repositioning the resident every two hours.
A record review of April-May 2020 documentation by PSWs failed to confirm the repositioning task for the resident was completed as per an identified schedule of every two hours.

A record review identified a skin and wound assessment on identified date in March 2020, identifying resident #033 skin condition on an identified area. A treatment note of the skin condition, four days later was documented by RPN #152 with further notes on identified dates in March and April 2020, that identified no significant changes in the resident's skin condition.

A review of the home's staffing schedule and interview with staffing coordinator revealed staff shortages to the wing starting April 6, 2020. From identified dates in April 2020, regular shortages of PSW staff and registered nursing staff were identified, often with half the number of PSWs on a specific shift as compared to the home's staffing plan.

An interview with PSW #219 who was scheduled up until identified date in April 2020, on a specific shift, identified they often worked short with two PSW and were unable to reposition the resident every two hours. PSW #194 who worked until an identified date in April 2020, identified that the repositioning care task could not be completed for all residents. The staff recalled resident #033 and stated they would see them in the same position until the end of their shift and sometimes with two staff, especially with agency staff, the specific care task could not be completed.
In separate interviews RPN #152 and RPN #156 identified that resident #033's scheduled repositioning was not being completed as required when the unit was short staff and with only two PSWs working resident's remained in bed. Both RPNs separately identified that between medication passes they would identify

the resident in the same position which would indicate the resident was not repositioned.

A final record review identified that on a date in April 2020, the resident's skin condition had deteriorated and in April 2020, was documented as a worsened specific skin condition. A note in April 2020, revealed that resident was crying with pain from the skin condition treatment. On identified date in April 2020, a skin and wound assessment note by RPN #152 confirmed a deteriorated skin condition and that the resident displayed signs of pain during the treatment.

An interview with the ADOC #137 revealed that when the wing was short staffed the priorities were other specific ADLs and that resident's remained longer in bed and were not getting up after a specific shift had place them back in bed. The ADOC confirmed that resident #033's skin condition had deteriorated and they had not been repositioned as required.

(110)

2. An area of non compliance was identified with r. 50.(2) (d) , as per policy, the sample size was expanded and included residents #077 and #062.

Resident #077

Resident #077 was admitted to the home on a date in March 2020. A review of the resident's admission assessment in March 2020, identified the resident's skin integrity healthy and intact.

Documentation through POC identified a skin observation of altered skin integrity of an identified area in April 2020, with no further alterations in skin integrity noted up until May 2020, where the resident's altered skin integrity was reported to the a registered staff. A progress note by a registered nurse in May 2020, revealed knowledge of the reported skin condition. The next documentation was a skin and wound assessment in June 2020, revealing a worsening skin condition.

A review of the resident's admission MDS assessment in March 2020, stated the resident required extensive assistance with the identified repositioning every

two hours and the specific level of assistance.

In separate interviews PSW #174 and PSW #214 shared that resident #077 required scheduled repositioning. PSW #214 shared the resident did not have a visual indicator for the need to reposition of every two hours and that the resident spent more time in bed when the wing was short staffed. The PSW stated the resident would lie in a specific position in bed. An interview with PSW #117 stated that when the wing had only 2 PSWs the residents were not taken out of bed into a chair for their meal and remained in bed and unable to reposition every two hours.

An interview with PSW #211 confirmed they worked a specified shift in April, 2020 and that the prior shift staff would ensure the resident was cleaned and in bed before the end of their shift. The staff stated when they were short staffed on their shift resident #077 did not get out of bed. The staff shared awareness that the resident required physical assistance and repositioning when in bed but that they were unable to provide repositioning as often as required.

A review of the resident's plan of care failed to identify a requirement for the resident to be repositioned every two hours.

An interview with the ADOC #137 stated that resident #077 did require repositioning by staff every two as they were unable to reposition themselves in bed. The ADOC also revealed there was nothing in the documentation system to alert staff to the resident's need for repositioning as it was missed being entered.

A further interview with the ADOC confirmed that when the PSW staffing levels were critically short, the focus was on other specified care interventions and not repositioning this resident required. In addition this resident spent more time in bed, identifying both contributing to the deterioration of the resident's skin condition over a short period of time.

Resident #062

Resident #062's written plan of care identified an specific number of team members were to provide care at all times; the resident was to receive

scheduled repositioning, as per identified posting on the overhead wall, when the resident was in bed, related to their skin condition.

A record review of April-May 2020 documentation by PSWs failed to confirm the resident was repositioning every two hours.

An interview with PSW #221 who worked full time on the specified shift up until an identified date in April 2020, identified the wing was often short with two PSWs for 35 residents and they were unable to provide scheduled repositioning every two hours.

In separate interviews RPN #152 and RPN #156 identified that resident #062 was not being repositioned as required when the unit was short staff with two PSWs and that it contributed to their deteriorating skin condition. Both RPNs, who worked full time most of April, separately identified that between medication passes they would identify the resident in the same position which would indicate the resident had not been repositioned every two hours. RPN #152 also shared that resident #062 had a tendency to be in a certain position which aggravated their skin condition and required staff to continue to provide repositioning which was not occurring. The RPN confirmed that unless a resident was independent and could get up on their own, residents, like resident #033 remained in bed when the wing was short staffed.

A review of the home's staffing schedule and interview with staffing coordinator revealed staff shortages to the unit starting on identified date in April 2020. From 19 identified dates in April 2020, regular shortages of PSW staff and registered nursing staff were identified, often with half the PSW staffing levels on a specified shift.

A record review in April 2020 revealed a 'Skin and Wound Care Assessment' that identified the resident's skin condition had significantly deteriorated from the prior assessment in April 2020.

An interview with ADOC #137 revealed that when the unit was short staffed the priorities were other specific care interventions and that residents remained longer in bed and were not getting up after specific shift had place them back in bed. The ADOC confirmed that resident #062s skin condition had deteriorated

and they had not been repositioned every two hours as was required. (110)

3. Related to Log #010420-20

During separate interviews, RPNs #130, #145, #148 #152 and #212 along with PSWs #101, #108, #117 and #120 indicated resident #009 was at high risk for altered skin integrity and required identified scheduled care of a resident in order to protect their skin and prevent further changes of altered skin integrity from occurring.

During record review, Inspector #672 reviewed resident #009's skin and wound assessments and observed that on specific date May 2020, resident #009 had a skin condition noted to an identified area. On a later specific date in May 2020, resident #009 was noted to have a second skin condition. Resident #009 was also noted to have another identified skin condition area, with a worsening condition requiring a medication order to be initiated.

During separate interviews, the Acting DOC, Corporate Clinical Consultant and the Wound Care Champion indicated the expectation in the home was that every skin condition should be assessed and documented on, on a weekly basis and the registered staff had received education regarding when and how to complete the weekly wound assessments.

During review of the weekly skin and wound assessments for resident #009 completed between specific dates March and June 2020 there was no indication that the resident was assessed weekly for their identified alteration to skin integrity for several specific dates in April, May and June.

A review of the progress notes further indicated that resident #009 sustained a change in altered skin integrity to an identified body part on specific date in June 2020. There was no documentation to support the resident's altered skin integrity was assessed by the registered staff on identified date in June 2020.

In relation to residents #027 and #062

A complaint was received by the Director through a Military observation report, identified date in May 2020, entitled "OP Laser - JTFC Observations in Long Term Care Facilities in Ontario", #3350-Op Laser 20-01 (COS). In relation to Altamont LTCH, the report indicated the Military staff members had several concerns related to the skin and wound care practices in the home and indicated the following:

"1(b) Significant number of residents have identified skin conditions as a result of prolonged bed rest...
1 (c) At time of arrival many of the residents had been bed bound for several weeks; No evidence of residents being moved to wheelchair for parts of day, repositioned in bed, or washed properly..."

During an interview with the first military clinical group on specific date in June 2020, revealed they had not observed staff assisting residents with activities of daily living (ADL) like toileting or repositioning during the specific dates in March and April 2020,

In relation to resident #062

Inspector #672 reviewed resident #062's skin and wound care assessments and progress notes related to skin care documented between March 1 and June 24, 2020, and observed on identified dates in March, April, May and June 2020, resident #062 was noted to have eight new multiple skin conditions on different identified body parts.

During a review of the weekly skin and wound assessments for resident #062 completed between identified dates in March and June 2020, there was no indication that the resident was assessed weekly for their identified alteration to skin integrity for several specific dates between March and June 2020.

In relation to resident #027

Inspector #672 reviewed resident #027's skin and wound care assessments and progress notes related to skin care documented between specific dates between March and June 2020, and observed the following specific skin conditions.

Through May until June resident #027 was noted to have five skin conditions plus six additional new skin conditions. There was no indication that the resident was assessed weekly for their identified alteration to skin integrity in May 2020.

During an interview, the Skin and Wound Care Coordinator/Chanmpion (SWCC) indicated they were responsible for completing the weekly skin and wound assessments for all residents in the home with skin conditions, which they were scheduled two days per week to complete. The SWCC further indicated they struggled to complete all of the weekly skin and wound assessments during that time frame, due to the amount of skin conditions, in the home. Due to the time constraints, the SWCC indicated there were times when they would assess a resident's skin condition(s), on one day and document the assessments on another. The SWCC further indicated there were other times when they would split the assigned weekly skin and wound assessments, therefore couldn't be sure of which assessments had actually been completed on the dates listed on the skin and wound assessments, because they had not documented any of the assessments as a late entry.

The licensee failed to ensure that residents #009, #027 and #062 were reassessed at least weekly by a member of the registered nursing staff when the resident was exhibiting altered skin integrity, which included specific skin conditions, between specific dates in March and June 2020. [s. 50. (2) (b) (iv)]

The severity of this non-compliance is determined to be actual harm, as the residents experienced worsening pressure ulcers. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous related areas of noncompliance noted in the home related to r. 50 (2), which included a VPC issued in a Critical Incident Report Inspection #2019_616722_0018, in October 2019.

(672)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 26. (4) The licensee shall ensure that a registered dietitian who is a member of the staff of the home,
(a) completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition; and
(b) assesses the matters referred to in paragraphs 13 and 14 of subsection (3).
O. Reg. 79/10, s. 26 (4).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 26. (4).

Specifically, the licensee must:

1) Develop and implement a system to ensure the registered dietitian completes a nutritional assessment for all residents on admission and whenever there is a significant change in a resident's health condition that includes an assessment of the resident's hydration status, and any risks related to hydration.
2) Conduct monthly audits for a six month period of time on all residents who have experienced a significant change in health condition to ensure the resident's hydration status and any risks related to hydration have been assessed.

Grounds / Motifs :

1. The licensee has failed to ensure that the registered dietitian who is a member of the staff of the home completes a nutritional assessment whenever there was a significant change in the resident's health condition and assesses the resident's hydration status, and any related risks to their hydration.

Resident #033

A record review of resident #033's health record identified that on a specified date in January 2020, the RD responded to a dietary referral to assess the resident's recurring skin condition. The note identified the resident consumed

10 servings of fluid, on average, per day, 125ml/serving or 1250mls. The documentation failed to include an assessment of the resident's estimated hydration needs as compared to the resident's average fluid intake of 10 servings.

A review of the home's policy entitled 'Nutrition/Hydration Risk Identification Tool', dated March 2019, identified a resident at moderate hydration risk when they are at poor or changed fluid intake defined as less than 75% but greater than 51% of their daily fluid requirement.
Resident #033's average intake of 10 servings per day, documented on that specified date in January 2020, would be 55% (less than 75% but greater than 51%) of their daily fluid requirement of 2283mls representing a hydration risk, that had not been assessed by the RD.

An interview with the RD identified that altered skin integrity impacts a resident's hydration needs and is a risk factor to their hydration status as adequate fluid intake plays a role in promoting healing of certain skin conditions. The RD revealed that they calculate a resident's fluid requirement higher and higher still depending on the certain skin condition.

A further record review identified documentation on a specified date in April 2020, by the RD in response to another referral flagging resident's deteriorating skin condition. The RD's documentation identified that the resident's food and fluid intake had declined but failed to include a hydration assessment.

An interview with the RD acknowledged the lack of a hydration assessment at the specified date in April 2020 referral.

On a later specified date in April 2020, a further deterioration of the skin condition was noted and generating another dietary referral.

(110)

2. Resident #018

On May 1, 2020 the RD determined resident #018 to be at high nutritional risk related to their specific medical issue and skin conditions and low intake. Resident #018's health record identified that the resident had a significant weight loss over a two month period.
On specified date in June 2020, a RD assessment was completed, in response to a skin impairment referral. The RD documentation identified that the resident consumed 5-8 servings of fluid or 625ml -1000ml per day. No documentation assessing the resident's fluid requirement, any shortfall in fluid intake or a hydration assessment was included

On a later specified date in June 2020 and RD assessment was complete in response to a referral that the resident's weight was below their goal weight range and decreased intake. The assessment note revealed what interventions were in place with no new approaches required.

Observations of resident #018 by Inspector #110 were conducted on specified dates in June 2020, at specific meals. The resident was not provided their level of mealtime staff assistance according to their plan of care. The resident's intake was poor.
Observations of resident #018 on another specified date in June 2020, identified their hot meal was served late, cold and the risk of influencing the desirability of the food and resident's intake.
An interview with the RD confirmed that lack of mealtime assistance, unpalatable food temperatures and skin condition were risk factors to a resident's nutrition and hydration status. The RD confirmed that these risk factors were not considered or assessed at the June 2020, referral assessments.

(110)

3. Resident #062

A record review of resident #062's health record identified a date in January 2020, where the resident was assessed and identified with altered skin integrity. The form included a check mark beside 'nutrition or hydration

intervention to manage skin problems.

A review of the resident's written plan of care in place on specified date in March 2020, identified the resident at moderate nutritional risk related to an identified body mass index, specific medical issue and skin conditions The resident received a specific textured diet with modified fluid consistency and required assistance by staff with food and fluid intake.

An interview with the RD identified that altered skin integrity increases a resident's hydration needs and that adequate fluid intake played a role in the healing of skin. The RD identified that a modified fluid consistency and the resident's specific medical conditions along with a dependence on staff for eating were considered a risk factors to a resident's hydration status.

On a specified date in March 2020, resident #062's health record identified a RD assessment that included acknowledgement of resident's areas of altered skin integrity. The noted stated the resident was drinking greater than 1500mls. The note also included reference to the resident's estimated fluid needs of 2330 ml/day but there was no assessment of the resident's hydration status.

A review of the resident's fluid intake monitored in the point click care (PCC) 'Look Back Report' on specific dates between March – April 2020 identified the resident met their estimated fluid intake on 5/35 occasions.

On specified date in April 2020, the RD reassessed the resident's fluid requirement and increased the resident's requirement to 2340-2630 ml/day in response to a worsening skin conditions referral assessment . The RD identified that the resident's fluid consumption was on average 1625ml per day. A hydration assessment was not documented.

The resident's record identified the resident with a specific clinical issue on specified dates in April and May 2020, increasing the resident's need for fluids. The resident presented with a medical condition on a specified date May 2020 and a physician note identifying the resident's deteriorating skin conditions on a specified date May 2020.

An interview with the RD acknowledged the lack of a hydration assessment on

specified dates in March and April 2020, when the resident's fluid intake consistently did not meet their estimated fluid needs.

(110)

4. Resident #097

A record review of resident #097's health record identified a hydration assessment at the time of the resident's admission on a specified date in August 2018. The assessment identified the resident required an estimated 2250mls of fluid per day.

On a specified date in December 2020, a RD note stated the resident consumed greater than 1500ml per day, with no hydration assessment or reference to their estimated fluid needs of 2250mls.
A record review of the Look Back Report for fluid intake in March 2020 - April 2020 revealed the resident seldom consumed the 2250hrs per day. From specified dates in April, 2020, the resident had an identified clinical issue that would impact the resident's hydration needs. Between specified dates in April 2020, the resident's fluid intake was reported as 500ml -750mls per day. On a specified date in April 2020, NP #149 documented for staff to continue to monitor resident and encourage intake of fluids to prevent dehydration.

On a specified date in May 2020, the RD documented an assessment that identified the resident 'drinks fair'. The documentation failed to identify a hydration assessment or interventions to address the resident's fair intake.

On a specified date in May 2020, the resident was identified with a specific medical issue and days later placed on specific intervention for fluid rehydration.

An interview with the RD acknowledged the lack of a hydration assessment when the resident's fluid intake was reported as greater than 1500ml per day on specified date December 2019 and when determined to be 'fair' on a specific

date in May, 2020.

The licensee failed to ensure that the registered dietitian who is a member of the staff of the home completes an assessment of the resident's hydration status, and any risks related to hydration.

The severity of this non-compliance is determined to be actual harm to the residents, which included sustaining worsening pressure ulcers. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home. (110)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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

Order # / No d'ordre : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 71. (4).

The licensee shall ensure that the planned menu items are offered and available at each meal and snack.

Specifically, the licensee must:

1) Develop and implement a system to ensure that all planned menu items are offered and available at each meal and snack.
2) Conduct daily audits of the dining room service, all prepared meal trays and nourishment carts to ensure that all planned menu items are available, according to the planned menu and internal policy #XI-G-20.00, dated April 2019. A documented record must be kept.

Grounds / Motifs :

1. The licensee has failed to ensure that planned menu items are offered and available at each meal and snack.

Resident #001

A complaint was received by the Director on April 14, 2020, from resident #001's family member, which indicated the resident was unwell and not offered adequate hydration.

During a telephone interview with resident #001's family member/complainant, they indicated that while resident #001 was in the home and ill, the resident would complain they were often thirsty, as it would take extended periods of time for staff members to respond to the call bell when they would request a drink.

According to the complainant, they would also call into the home to attempt to get a staff member to bring resident #001 a drink. On an identified date, the complainant contacted emergency services on their own and initiated the transfer of resident #001 to the local hospital. Resident #001 was admitted to the hospital, where they passed away.

During a record review, Inspector #672 observed over multiple days in an identified month,leading up the resident's transfer to hospital, resident #001 was documented to have consumed less than half of their required fluid intake. A review of resident #001's hospital record, admitting diagnosis, included a diagnosis consistent with poor fluid status.

During separate interviews, PSWs #117, #120, #121 and #174 indicated that resident #001 had become ill and often complained they could not tolerate the food being served. PSWs #117, #120, #121 and #174 further indicated that resident #001 would often complain of thirst and had a water jug kept at the bedside, which staff tried to keep full, but due to staffing concerns around that time, indicated it was difficult to ensure "small tasks like that were being done when we were just trying to make sure everyone was clean and fed".

A review of the home's hydration policy, dated April 2019, identified the residents are to be offered a minimum of 1500-2000 ml of fluid daily unless specific care plans indicate an individualized fluid goal. The standard included that fluids were to be offered as follows:

Breakfast - 250ml milk, 125ml juice, 180ml water, 180 ml tea and coffee
Morning Snack- 125 ml cold beverage (fruit drink/water/milk) or 180 ml tea and coffee
Noon Meal -125ml milk, 180ml water, 125ml fluid as soup or juice, 180 ml tea and coffee
Afternoon Snack- 125 ml cold beverage (fruit drink/water/milk) or 180 ml tea and coffee
Evening Meal- 125ml milk and tomato juice, 180ml water, 180 ml tea and coffee
Evening Snack - 125 ml cold beverage (fruit drink/water/milk or 180 ml tea and coffee

Resident #063 interview by Inspector #110.

An interview with resident #063 revealed they were never offered milk and liked milk to drink. The resident shared they would drink milk especially since they have been given orange juice at every meal and have become tired of it.

A review of the home's hydration, policy #XI-G-20.00, dated April 2019, identified the residents are to be offered a a minimum of 1500-2000 ml of fluid daily unless specific care plans indicate an individualized fluid goal. The standard included milk to be offered as follows:

Breakfast - 250ml milk
Morning Snack- 125 ml cold beverage (fruit drink/water/milk) or 180 ml tea and coffee
Noon Meal -1/2 cup 125ml milk
Afternoon Snack- 125 ml cold beverage (fruit drink/water/milk) or 180 ml tea and coffee
Evening Meal- 1/2 cup 125ml milk or tomato juice
Evening Snack - 125 ml cold beverage (fruit drink/water/milk or 180 ml tea and coffee

On May 22, 2020, Inspector #672 observed that lunch meal trays were served with one 200ml juice box and the nearby beverage cart did not include milk.

PSW #108 stated 'the carts never have milk on them enough to be served to residents as a drink, only a small jug for mixing for tea/coffee. Further observations were consistent with milk not being offered.

Interviews with PSW #211 and #235, who worked between April and May 2020, confirmed that milk was not available or served as a drink at meals and snacks and PSW #235 stated they were only provided a 1L milk jug for upwards of 35 residents at mealtimes on the cart.

An interview with the RD confirmed that milk was part of the planned menu and hydration program and that milk was to be offered to residents. [s. 71. (4)]

(110)

2. Inspectors #110 and #672 arrived onsite of the LTCH on May 21, 2020. Inspector #672 observed multiple nourishment passes and meal services noting that planned menu items were not offered and available at each meal or snack for multiple residents in the home between May 21 and June 30, 2020.

May 21, 2020 – Afternoon snack -Wing 4
Not all residents were offered fluids according to the planned menu. PTA #102 stated PSWs usually serve residents who ask for a drink or if they have a specialty drink sent from the kitchen.

May 22, 2020 – Morning snack -Wing 3
PSWs were not observed offering every resident a drink from the cart according to the planned menu. PSW indicated to Inspector that a drink is provided to the resident "if we know they always like a cup of tea/coffee at this time of day, if they ask for a drink or if they have a specialty drink sent from the kitchen".

May 22, 2020 -Lunch Service Wing 4
Meal trays were served with 1 serving of fluid, a 200ml juice box.
There was a small cart delivered along with the meal tray cart containing 1 pot of tea, 1 pot of coffee, 1 jug of juice and 1 small jug of water. No milk was present.
There were approximately 32 residents on Wing 4 at this time.
Fluids were observed not being offered to all residents with their meals according to the planned menu. PSW #108 stated the fluids on the small cart (tea/coffee/juice/water) were provided "if a resident asked or for the residents they know want tea/coffee with their meal, but not all do ask". PSW #108 also stated the carts "never" have milk to be served to residents as a drink, only a small jug for mixing with tea/coffee.

May 22, 2020 -Lunch Service Wing 3
Meal Trays were served by 1305hr, most residents were served 1 serving of fluid, a 200ml juice box with their tray. PSWs indicated they only serve fluids from the small beverage cart to those residents who ask for another drink with their meal, or for the residents they know like a cup of tea/coffee. The accompanying fluid cart had 1 jug of tea/coffee/water. No juice or milk was present. PSW #106 indicated the cart "never" has milk on it with the intention to be served to residents as a drink, only to be mixed with tea/coffee.

May 22, 2020 – Afternoon snack Wing 4
Residents, #029, #031, #030, #019, #021, #027, #047, #048, #020 and #026 were not offered a drink during the afternoon snack pass in keeping with the planned menu.

May 22, 2020 – Afternoon snack observation Wing 3
Residents #049, 041, 050, 037, 017, 028 and 006 were not offered a drink during the afternoon snack pass in keeping with the planned menu.

May 25, 2020 – Afternoon snack observation Wing 4
Eight residents were not offering a drink during the afternoon snack pass in keeping with the planned menu.

Wing 3
Resident #029 was not offered a drink and PSW #108 stated the "resident didn't ask for a drink and doesn't normally get one at this time of the day". Following the Inspector's question the PSW served the resident a drink which was all consumed.

May 25, 2020 -Dinner observation Wing 3
1740hrs - All dinner trays were prepared and sent to the wings with 1 juice box 200ml on each tray and a prepacked meal in a disposable box with disposable cutlery. A beverage cart was sent along with the trays. The beverage cart consisted of 1 pot of tea/coffee/decaf coffee and 1 very small jug of water, 2 -237ml cartons of 2% milk, which the PSW indicated was to be used to mix with tea/coffee and not as a drink option of the residents.
Both during and after the meal, staff were observed not offering the residents any additional fluids from the small beverage cart leaving residents, including residents #017, #073, #060, #037, #043, #074, #072, #041, #050 and #071 who receiving 1-200ml juice box with their meal and were not offered the planned menu items of 125ml milk and tomato juice, 180ml water, 180 ml tea and coffee.

Wing 4
Staff were observed not offering all of the residents fluids from the beverage cart leaving residents to receive 1-200ml juice box as their fluid with their meal. PSW #173 indicated staff only served additional fluids outside of the juice box on the

meal tray to residents who staff "knew they liked tea/coffee with meals" or "if the resident asked". Residents were not offered the planned menu.

On May 26, 2020 after several observations by Inspector #672 a conversation took place between Inspectors #110 and #672 and the Director of Dietary Services #104 and Sienna Clinical Supervisor #103 around residents being offered one 1- 200ml tetra box of juice each meal tray and not following the home's hydration policy or planned menu.

May 27, 2020 -Lunch Observation
Lunch meal trays on 3 units were still being served with only 1 juice box (200ml) present on the tray and not being offered the planned menu for fluids outside of a 200ml juice box.

May 27, 2020 -Afternoon snack pass
Residents were observed not being offer a drink in keeping with the planned menu at the afternoon snack pass.

May 30, 2020 – Lunch Observation
Twelve residents, including resident #039 were observed being served their meal tray with empty cups which remained unfilled throughout the lunch service. Resident #039 was overheard, very loudly calling out for a drink at 1315hrs, but staff did not respond to the resident's request.

On June 1, 2020 Inspector #672 observed seven resident's including resident #024 not being offered a drink or snack at the afternoon snack pass according to the planned menu. At 1529hr resident #024 was overheard loudly calling out into the hallway stating they were very thirsty and requesting a drink. Staff did not respond to the resident's request until 1542hr, when Inspector asked PSW #139 if the resident would be provided with fluids and/or a snack. The resident was observed then being provided with a drink, consuming it immediately and then asking for another.

On June 1, 2020 at 1610hrs a second conversation took place between the acting ED #140, Sienna Clinical Supervisor #103 and Inspectors #110 and #672 that residents were still not being offered drinks according to the planned menu. [s. 71. (4)]

Resident #020

During a record review, resident #020 was noted to be at high nutritional risk for reasons that included their weight status and risks of dehydration. The resident was also at high risk for heat related illness and therefore required fluids to be encouraged. The resident was identified as requiring staff assistance for food and fluid intake.

Observations of resident #020 over a three week periods revealed that resident #020 was not offered the planned menu items, including fluids, at each meal and snack on ten separate occasions.

Resident #029

During record review, resident #029 was noted to be at moderate nutritional risk for reasons that included their weight status and increased fluid needs. Resident #029 was at high risk for heat related illness and therefore required fluids to be offered and encouraged. The resident was identified as requiring staff assistance for food and fluid intake.

Observations of resident #029 over a week period revealed that resident #029 was not offered planned menu items, including fluids, at each meal and snack on six separate occasions.

Resident #030

During a record review, resident #030 was noted to be at high nutritional risk for reasons that included their weight status. The resident was identified at high risk for heat related illness, therefore required fluids to be encouraged. The resident was identified as requiring staff assistance for food and fluid intake.

Observations of resident #030 over a three week period revealed that resident #030 was not offered planned menu items, including fluids, at each meal and snack on six separate occasions.

Additional observations over the course of the inspection identified 27 other

residents who were also not offered planned menu items on multiple occasions, including fluids, at each meal and snack.

During separate interviews, PSWs #101, #108, #110, #116, #117, #127, #132, #139, #181, #183 and #185, RPNs #115, #130, #212 and PTA #102 indicated residents were only served fluids during nourishment passes or additional fluids outside of the 200ml tetra juice boxes during meals if a resident asked or for the staff knew the residents wanted tea/coffee with their meal. Several PSWs also stated the fluid carts "never" had milk on them to be served to residents as a drink, staff only had a small carton for mixing with tea/coffee.

During separate interviews, the Acting DOC, Acting ADOC, Corporate Clinical Consultant, Acting Executive Director and the FSM indicated the expectation in the home was for every resident to be offered a drink and snack during every nourishment pass and additional fluids as well as the 200ml tetra juice boxes served during meals according to the internal nutrition and hydration policy.

The licensee failed to ensure that planned menu items were offered to multiple residents between May 21 and June 17, 2020, at each meal and snack.

The severity of this non-compliance is determined to be actual harm, as the residents experienced significant weight loss. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home. (672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 010

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 73. (1) 6.

The licensee shall ensure that food and fluids are served at a temperature that is both safe and palatable to the residents.

Specifically, the licensee must:

1) Ensure that food and fluids are served at a temperature that is both safe and palatable to the residents.

Grounds / Motifs :

1. The licensee has failed to ensure that food and fluids served at a temperature that is both safe and palatable to the residents.

The home is a 4 wing design accommodating 158 residents.

On March 25, 2020 wing 3 went on isolation precautions and 29 residents began meal service on trays. On March 31, 2020, the remaining residents in the home, wings 1, 2 and 3 went on isolation precautions and also began tray service.

Staff interviews identified the following practice had been in place with respect to tray service.

Food was served on disposable plates covered with saran for approximately 6 weeks then cardboard folding takeout containers for 4 weeks. There was no thermal system in place to keep hot food hot.

Inspectors #672 and #110 arrived on site in the home on May 21, 2020.

During the course of the inspection the following interviews and observations were conducted with respect to the temperature palatability of the food:

May 22, 2020 - Inspector #672
Resident #032 complained their hot meal was served to them cold. Residents #007, #008, #040, #039 all indicated their meals were served cold therefore they didn't enjoy/eat the entire meal. Resident #022 indicated the meal "could have been warmer, but it wasn't terrible".

June 13, 2020 - Inspector #672
Residents #038, #032, #039 and #040 indicated the soup and the meat were too cold and couldn't be finished.Resident #042 stated the soup was too cold to enjoy/eat.
Resident #043 stated the soup and meat were too cold and did not eat the meal. The resident declined the Inspectors offer to have the meal reheated, stating they had "lost their appetite".
Resident #045 – stated the meat and soup were too cold to eat, and left the tray untouched. the resident also declined the Inspectors offer to have food reheated.
Resident #046 – Stated they could not eat the meat and soup as it was too cold. Inspector requested a bowl of soup be reheated for resident. Soup reheated and the resident ate the entire serving.

June 16, 2020 -Inspector #672
Resident #052 was observed still eating their eating lunch at 1350hr and stated it was difficult to eat because it was not palatable due to being served cold.

June 17, 2020 - Inspector #672
Resident's #065 - stated the chicken fingers were served cold and resident #027 stated they were served cold and therefore did not eat their entire meal.
Resident's #068, #069 and #070 further indicated their lunch meal had been served cold, which they did not enjoy. Resident #045 stated "well, it should have been warm but it wasn't. I wasn't too hungry anyway, so I guess it didn't matter."

June 18, 2020 Inspector #110 entered wing 3 at 1200hrs. At 1215hr an upright cart of meal trays covered in plastic arrived onto the wing. At 1258hrs resident #018 was served their meal. Resident #018 was severely cognitively impaired and unable to express the temperature palatability of their meal.

At 1258hrs the pureed food was congealed in appearance with no presence of steam.

Food temperatures were taken and probed as follows at the time the resident

was served as follows:
Pureed meat - 86 degree F
Pureed vegetables -85 degree F
mashed potatoes - 101 degree F
Soup -130 degree F
The reading from the temperature probe were confirmed by PSW #192.

June 20, 2020 - Inspector #110
Resident #063 shared that the lunch meal 'wasn't really hot enough'.

The residents remained on tray service until the last day the Inspectors were on-site or June 30, 2020.

An interview with the Director of Dietary Services confirmed that the home's policy required hot food to be served at the point of service greater than or equal to 140 degree Fahrenheit.

The severity of this non-compliance is determined to be actual harm, as the residents experienced significant weight loss. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home. (110)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre : 011

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 73. (1). 9 and s. 73. (1) 10.

Specifically, the licensee must:

1) Ensure that the resident is provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

2) Ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required assistance.

Grounds / Motifs :

1. The licensee has failed to ensure that the resident is provided with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report, dated May 14, 2020, reporting inadequate nutrition of residents due to underfeeding.

During the inspection period staff interviews revealed how tray service placed added demands on staff to provide total feeding assistance to those residents requiring it and encouragement to others, especially when short staffed. The Director of Dietary Services identified how the dining room service allowed for groupings of 4 residents to 1 PSW per table; two residents being provided total feeding assistance while two residents are provided with the necessary encouragement and prompting while tray service to each resident does not provide for staffing efficiency.

Resident #072

An interview with RPN #125 who worked full time on wing 3 over an identified 20 day period stated that some residents who would normally be independent with feeding declined and they did have the hands to assist them. The RPN stated they felt the residents declined quicker since they were unable to assist them with fluids and food to the degree they should have and identified resident #072

as requiring more eating assistance than was provided and noticed their overall intake was less. The RPN stated they would bring the resident out into the hallway so anyone passing could encourage the resident but staff were often too spread out and in rooms assisting other residents.

Resident #072's plan of care identified their level of mealtime assistance over this identified 20 day period.

Interviews with PSW #122 stated there were usually 3 PSWs instead of 4 and that 9-11 residents required feeding assistance and four required encouragement and prompting at mealtimes. The PSW stated that resident #072 required an identified level of assistance but the priority was given to those resident's who required total feeding assistance. PSW #204 confirmed resident #072's need for mealtime assistance, stating the resident sometimes required even more staff assistance at mealtimes.

A record review of the staffing schedule identified resident's wing often had 3 instead of 4 PSWs on days (covering breakfast and lunch) and 2 instead of 4 PSW on afternoons (covering dinner) over an identified period of time.

A record review of the Weight Summary Report identified that resident #072 lost significant weight over the same identified two and one half month period.

A further record review identified that at the end of the two and one half month period the resident's plan of care for mealtime assistance was changed to require additional mealtime assistance.

(110)

2. Resident #018

Resident #018 resided on wing 3 until an identified time at which time they were moved to wing 2.

Interviews with PSWs #122 and #204 from wing 3 identified resident #018's level of mealtime assistance prior to the resident's move to wing 2.

A review of the resident's written plan of care identified their level of dependence on staff for mealtimes.

Meal observations of resident #018 were completed as follows:

On an identified date- by Inspector #672
1216hrs- resident's lunch tray of pureed chicken, mashed potatoes and carrots was served and set up for resident.
1231hrs- resident had not eaten and unassisted by staff. Inspector #672 inquired with staff and was informed that the resident's level of mealtime assistance stated was not the level identified in the resident's plan of care.
1250hrs -PSW #181 assisted the resident with their meal but not drinks. No fluids were offered or taken by the resident.

On a second identified time - by Inspector #110
1740hrs resident was served their meal tray and set up.
1800hrs resident had not eaten and was unassisted by staff. Inspector approached RPN #230.

On a third identified date - by Inspectors #110 and #672.
1258hrs resident was served their meal tray late and set up. Trays arrived to the unit at 1215hrs. Temperatures of hot food were taken when served to the resident and cold. PSW #192 set up the resident's meal tray and reported to Inspectors that the resident was independent in eating. PSW #192 returned to the resident at 1311hrs.

A record review of the resident's Weight Summary Report identified the resident

lost significant weight over an identified two and one half time period.

(110)

3. Resident #015

Resident #015's plan of care identified their level of feeding assistance.

Interviews with PSW #213 and RPN #152 confirmed awareness of the resident's level of assistance.

A review of the progress notes identified on an identified date the resident had a change of condition but not showing signs and symptoms. A progress note a few weeks later revealed the resident's condition was resolved.

An interview with PSW #211 identified they worked 25 evening shifts on resident #015's wing over an identified period of time. The PSW reported they often worked short with only 2 PSWs for 35-24 residents and on two occasions worked alone. The PSW shared at dinner they would serve everyone their meal tray then go back to provided total feeding assistance to those residents requiring to be fed. The PSW shared they were unable to provide residents including resident #015 with the level of mealtime assistance they required. The PSW shared that when residents were unwell and dying you also wanted to spend time with them but they did not have sufficient time for everything.

A record review of the 'Weight Summary Report' identified that resident #015 lost significant weight over an identified two and one half month period of time.

Interviews with RPNs #152, #156 and #125 all identified that when staffing levels were short residents requiring total assistance with eating were the priorities while those resident's requiring encouragement and supervision were not supported at meals in the manner they required.

A further review of resident's #015's plan of care identified an update on June 5, 2020 to their level of feeding assistance requiring further staff assistance at mealtimes.

On an identified date the following meal observation of resident #015 was conducted by Inspector #672 .
1232hrs lunch meal tray was served while resident was sitting in bed. Staff indicated resident was independent with meals. The tray was not set up.
1243hrs RPN went in to administer resident's medications and was not observed to set-up or encourage the resident with their meal; the resident had not as yet eaten.
1250hrs resident's meal container remained unopened.
1259hrs PSW #181 entered resident's room and asked the resident if they were finished with their lunch while removing the meal tray.

(110)

4. Resident #009

During a record review, resident #009 was noted to be at high nutritional risk with identified circumstances and at high risk for heat, therefore required fluids to be encouraged. The resident was dependent on staff with meals and fluid intake.

During resident observations over a 10 day period, Inspector #672 observed that resident #009 was served food and/or fluids on six separate occasions, without the level of mealtime assistance being provided to the resident to ingest them.

During separate interviews, PSWs #101, #127 and #132 verified that resident #009 was dependent on staff assistance at mealtimes to ingest food and/or fluids, and the expectation in the home was for each resident to receive the level of assistance they required.

Resident #020

During a record review, resident #020 was noted to be at high nutritional risk with identified circumstances and at high risk for heat related illness, therefore required fluids to be encouraged. The resident required staff assistance with meals and fluid intake.

During observations of resident #020 over a 25 day period, Inspector #672 observed that resident #020 was served food and/or fluids on nine separate occasions, without the required level of mealtime assistance being provided to the resident to ingest them.

During separate interviews, PSWs #108, #132 and #216 verified that resident #020 was dependent on staff assistance at mealtimes to ingest food and/or fluids, and the expectation in the home was for each resident to receive the level of assistance they required.

Resident #029

During record review, resident #029 was noted to be at moderate nutritional risk with identified circumstances and at high risk for heat related illness, therefore required fluids to be offered and encouraged. The resident was dependent on staff with meals and fluid intake.

During observations of resident #029 over a nine day period, Inspector #672 observed that resident #029 was served food and/or fluids on four separate occasions, without the required level of staff assistance being provided to the resident to ingest them.

During separate interviews, PSWs #101, #127 and #132 verified that resident #029 was dependent on staff assistance at mealtimes to ingest food and/or fluids, and the expectation in the home was for each resident to receive the level of assistance they required.

Further resident observations made over a five week period, Inspector #672 identified residents #006, #011, #012, #013, #014, #015, #016, #018, #019, #021, #026, #030, #037, #048, #063, #072 and #080 were served food and/or

fluids without the required level of staff assistance being provided to the resident to ingest them.

During separate interviews, RPNs #130 and #145 and RNs #129 and #215 verified that residents #009, #020 and #029 required staff assistance to ingest food and/or fluids and the expectation in the home was that staff provide the level of assistance required by each resident to ensure optimal intake of both food and fluids.

(672)

5. Resident #056

An interview with PSW #116 who worked full time in an identified month shared that staffing was dramatically impacted as the wing normally had four PSWs on days and staffing went to three and sometime two PSWs for 37 residents in the beginning. The PSW stated that resident #056 needed more assistance at meals but they did not have the time to spend with them and that the resident lost weight.

An interview with RPN #152 who also worked full time over an identified period stated that the time in question was "horrible" for staffing and the priority went to those residents who required feeding. The RPN isolated resident #056 as a resident who required more assistance than they were able to provide and as a consequence the resident lost weight. They continued to say that whenever they could they would provide the resident a nutritional supplement and that they were one of the residents who needs increased and they could not accommodate for them.

A record review identified the resident's plan of care for eating changed after the short staffing period to requiring more staff assistance at mealtimes.

A record of the Weight Summary Report identified resident #056 had lost significant weight over a two and one half month period.

Additional observations:

On an identified date, Inspector #672 observed that residents #009 and #020 were sent labelled specialty drinks from the kitchen at the afternoon nourishment pass. Inspector #672 observed the drinks being delivered to the resident's bedroom, but no assistance was provided to either resident to ingest the drink as needed. During observations on another date, Inspector #672 observed resident #029 had a drink delivered to a table in their bedroom, but resident #029 was sitting in another area of their room and unable to access or reach the drink. No staff member returned to provide any assistance to resident #029 for them to ingest their drink as needed.

On an identified date, Inspector #672 observed the morning and afternoon nourishment passes along with lunch meal service. Observations included multiple residents, including residents #009, #020, and #029, not being offered assistance with ingesting food and/or fluids during the nourishment passes or during meal service as needed.

During separate interviews, the Acting DOC, DOC, Corporate Clinical Consultant and DDS indicated the expectation in the home was that staff provide the level of assistance required by each resident during nourishment and meal services to ensure the optimal intake of both food and fluids.

The licensee failed to ensure that multiple residents in the home, including residents, #072, #018, #015, #056, #030. #009, #020 and #029 were provided with personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

The severity of this non-compliance is determined to be actual harm, as the residents experienced significant weight loss. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home.
(110)

6. The licensee has failed to ensure that proper techniques were used to assist residents with eating, including safe positioning of residents who required

assistance.

During resident mealtime observations over a five week period, Inspector #672 observed multiple PSWs feeding residents food and/or drinks without using proper techniques or the safe positioning of residents including residents #009, #020, #030.

Resident #009:

During a record review, resident #009 was noted to be at high nutritional risk for identified reasons including having swallowing difficulties.

During a resident observation on an identified date, at 1500hrs, Inspector #672 observed PSW #101 assist the resident with a drink and noted the PSW attempted to provide the resident their drink without raising the head of the bed (HOB) and the resident was laying flat. Resident #009 was immediately observed to cough on two occasions, therefore the PSW stopped assisting the resident and the drink was not ingested.

During separate interviews, PSWs #101 and #127 indicated they did not position resident #009 in a seated position during ingestion of meals/fluids due to the resident experiencing increased pain when in an upright, seated position.

Further observations of resident #009 by Inspector #672 identified the resident being assisted with meals and/or fluids on six separate occasions without the use of proper techniques, which included safe positioning.

Resident #020

During record review, resident #020 was noted to be at high nutritional risk for identified reasons including having swallowing difficulties.

A resident observation, on an identified date at lunch, revealed PSW #108 assisting resident #020 with their meal while the resident was positioned in bed in an almost flat position; the HOB was barely raised.

Further observations by Inspector #672 of resident #020 revealed the resident

being assisted with meals and/or fluids on four separate occasions without the use of proper techniques, which included safe positioning.

Resident #030

During a record review, resident #030 was noted to be at high nutritional risk for identified reasons including having swallowing difficulties.

Further observations of resident #030 revealed the resident being assisted with meals and/or fluids on three separate occasions without the use of proper techniques, which included safe positioning.

Additional resident observations over a five week period by Inspector #672 revealed residents #007, #021, #025, #041, #050, #064, #068, #071 and #072 struggling to ingest food and/or fluids, as proper techniques including safe positioning, were not implemented on multiple occasions.

During separate interviews, RPNs #125 and #172 stated the expectation in the home was that when residents were eating or drinking, they should be in a high Fowler's position.

During separate interviews, the Acting DOC, DOC, Corporate Clinical Consultant and DDS indicated the expectation in the home was that staff provide safe positioning and proper feeding techniques every time a resident is assisted with food and/or fluid intake.

The licensee failed to ensure that multiple residents in the home, including residents #009, #020 and #030 were provided with safe positioning and proper feeding techniques every time the residents were eating and/or assisted with food or fluid intake. s. 73. (1) 10.

The severity of this non-compliance is determined to be minimal harm/risk to the residents. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

(672)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Sep 30, 2020

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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Order # / No d'ordre : 012

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(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).

Order / Ordre :

The licensee shall be compliant with O. Reg. 79/10, s. 73. (2).

The licensee shall 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.

Specifically, the licensee must:

1) Develop and implement a system to ensure that any resident who requires assistance with food/fluid intake is not provided with a meal or nourishment until someone is available to provide the assistance required by the resident. A documented record must be kept.
2) Educate all staff members who assist residents with food and fluid intake on the requirement that no meal or nourishment is to be provided to any resident who requires assistance with intake until someone is available to provide the assistance required by the resident. A documented record must be kept.
3) Conduct weekly audits of the meal and nourishment services, rotating through each of the Resident Home Areas, meals and nourishment services, for a three month period of time, to observe that no residents who require assistance with food/fluid intake are provided with a meal or nourishment until someone is available to provide the assistance required by the resident. A documented record must be kept.

Grounds / Motifs :

1. 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.

This IP was initiated in response to the Canadian Armed Forces (CAF) observation report, dated May 14, 2020, reporting inadequate nutrition due to underfeeding.

Over a five week period, Inspector #672 observed multiple incidents of PSWs serving residents including resident #009, #011, #020 and #029 their meal trays, snacks and/or fluids before a staff member was available to assist the resident with their nutritional intake.

Related to resident #009

During a record review, resident #009 was noted to be at high nutritional risk and required an identified level of staff assistance with their food/fluid intake.

During a resident observation on an identified date, resident #009 was observed to have their afternoon nourishment served to them at 1500hrs, without a staff member being available to assist the resident.

Further observations of resident #009 revealed the resident being served meals and/or fluids on six separate occasions without a staff member being available to assist the resident with their intake. On a separate occasion resident #009 was observed to have their lunch meal tray delivered to their room at 1214hrs. The meal tray was placed on the dresser beside the resident's bed and lids removed, but staff were not present in the room to assist the resident to consume their meal. At 1236 hours, staff were still not present to assist the resident with their meal and resident #009 was observed to be asleep in bed. Inspector #672 approached RPN #130 and asked if there was a staff member assigned to assist the resident. RPN #130 indicated a PSW would be in as soon as possible to assist the resident, as they were all busy assisting other residents with their meals. PSW #127 arrived at 1242 hours to assist resident #009 with their lunch meal. The tray was removed at 1257 hours and PSW #127 indicated the resident did not wish to eat any more. Inspector #672 reviewed the resident's meal tray, and it appeared that the resident had only eaten a few bites of their

meal and the cups appeared to remain full.

During a record review, Inspector #672 noted resident #009 lost significant weight over a two and a half month period.

Related to resident #011

During record review, resident #011 was noted to be at high nutritional risk and required an identified level of staff assistance with their food/fluid intake.

Observations of resident #011 over a three week period, revealed the resident being served meals and/or fluids on four separate occasions without a staff member being available to assist the resident with their intake.

During an observation of resident #011 on an identified date, Inspector #672 observed the resident was served their lunch meal at 1212 hours, with no staff members present to assist the resident with their meal. At 1236 hours, the meal tray was still sitting opened in place, therefore Inspector #672 asked RPN #152 if a staff member was assigned to assist the resident. RPN #152 asked PSW #186 to assist the resident with the meal at 1242 hours. Inspector #672 returned to check on resident #011 at 1300, 1315 and 1325 hours and observed that three drinks served with the meal still had their lids closed and did not appear to have been touched. The lunch tray was removed from resident #011's room at 1325 hours. Inspector #672 then picked up each of the three cups and noted each felt completely full. A review of resident #011's meal intake documentation indicated the PSW did not document the resident's intake at this identified meal.

A record review of the Weight Summary Report identified the resident lost weight over a four month period.

Related to resident #020

During record review, resident #020 was noted to be at high nutritional risk and required an identified level of staff assistance with their food/fluid intake.

During an observation of resident #020 on an identified date, Inspector #672 observed resident #020 had the lunch meal tray delivered to them at 1245

hours. The meal tray was placed opened on the resident's bedside table, but staff were not present in the room to assist the resident consume their meal. At 1308 hours, there were still no staff available to assist the resident. Inspector #672 approached RPN #130 and asked if there was a staff member assigned to assist resident #020 with their meal. RPN #130 indicated a PSW would be in as soon as possible to assist the resident, as they were all busy assisting other residents with their meals. At 1318 hrs, staff were still not present to assist the resident with their meal, therefore Inspector #672 reapproached RPN #130 and asked if there was a staff member assigned to assist the resident. RPN #130 directed PSW #108 to assist resident #020 with their meal at that time. At 1321 hours, PSW #108 exited resident #020's room and indicated to RPN #130 that the resident had finished their meal. As less than four minutes had passed, Inspector #672 entered resident #020's room, inspected the meal tray and observed that all of the lids on resident #020's cups remained closed and the cups were full, it appeared that 100% of the meal was still present and the dessert pudding cup remained unopened. The Inspector reported the findings to RPN #130, who did not follow up with PSW #108, therefore Inspector reported the findings to the Acting Executive Director and the Corporate Clinical Consultant. The Corporate Clinical Consultant indicated they would follow up with the staff member.

Observations of resident #020 over a four week time period revealed the resident being served meals and/or fluids on ten other occasions without a staff member being available to assist the resident with their intake.

A record review of the Weight Summary Report revealed the resident lost significant weight over a four month period.

Related to resident #029

During record review, resident #029 was noted to be at moderate nutritional risk and required an identified level of staff assistance with their food/fluid intake.

During an observation of resident #029 on an identified date, Inspector #672 observed resident #029 had their lunch meal tray delivered at 1235 hours. The meal tray was placed opened on the resident's overbed table, but no staff were present in the room to assist the resident consume their meal. At 1300 hours,

there were still no staff available to assist the resident #029 with their meal and the resident presented as very agitated, calling out and pointing to their meal tray, which was out of reach of the resident. Inspector #672 attempted to explain to resident #029 that a staff member would be there shortly to assist with the meal, but the resident continued to be agitated, therefore Inspector #672 approached RPN #130 and asked if there was a staff member assigned to assist the resident. RPN #130 directed PSW #127 to assist resident #029 with their meal and they arrived to assist resident #029 at 1317 hours. Resident #029 was noted to de-escalate immediately once they began eating their meal.

Further observations of resident #029 over a four week period, revealed the resident being served meals and/or fluids on five other occasions without a staff member being available to assist the resident with their intake.

A record review of the Weight Summary Report identified the resident had lost weight over an identified three month period.

Additional resident observations during the inspection period , revealed 22 residents being served food and/or fluids prior to a staff member being available to assist the resident.

During separate interviews, PSWs #108, #127, #181, #185 and #186 indicated the expectation in the home was for food and/or fluids to be served to a resident who required assistance only when there was a staff member available to assist the resident. PSWs #108, #127, #181, #185 and #186 further indicated meals or nourishment were being served to residents prior to staff being available to assist due to there being more residents on each wing who required assistance with their meal than staff members who were available to assist them.

During separate interviews, the Acting DOC, DOC, DDS and the Corporate Clinical Consultant indicated the expectation in the home was for meal trays and/or nourishment were to be served to a resident only when there was a staff member available to assist the resident, according to the resident's planned care needs.

The licensee failed to ensure that multiple residents in the home, including residents #009, #011, #020 and #029, who required assistance with eating or

drinking, were not served food or fluids until someone was available to provide the assistance required by the resident.

The severity of this non-compliance is determined to be actual harm, as the residents experienced significant weight loss. The scope of this non-compliance was noted to be wide spread as it included three out of three residents. The compliance history indicated that there had been previous non-related areas of non-compliance noted in the home. (672)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Sep 30, 2020

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

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

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

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l’inspecteur

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l’envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l’envoi de la télécopie. Si un avis écrit de la décision du directeur n’est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l’expiration de ce délai.

Le/la titulaire de permis a le droit d’interjeter appel devant la Commission d’appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d’un ordre ou des ordres d’un inspecteur ou d’une inspectrice conformément à l’article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n’a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d’audience, il ou elle doit, dans les 28 jours de la signification de l’avis de la décision du directeur, donner par écrit un avis d’appel à la fois à :

la Commission d’appel et de révision des services de santé et au directeur

À l’attention du/de la registrateur(e)
Commission d’appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d’appel, la CARSS en accusera réception et fournira des instructions relatives au processus d’appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 29th day of July, 2020

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur : DIANE BROWN

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