Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

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

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

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 4, 2019	2019_657681_0026	016777-19, 016960-19, 016973-19, 017627-19, 017634-19, 018292-19	Complaint

Licensee/Titulaire de permis

Board of Management for the District of Parry Sound West
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

Belvedere Heights
21 Belvedere Avenue PARRY SOUND ON P2A 2A2

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

STEPHANIE DONI (681), AMY PAGE (749), TRACY MUCHMAKER (690)

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): September 30, 2019 - October 4, 2019. Additional off-site activities were completed on October 9, 16, and 17, 2019.

The following complaints submitted to the Director, were inspected during this Complaint inspection:

- One complaint related to housekeeping services and the cleanliness of the home.

- One complaint related to staffing levels in the home, dietary services, and infection prevention and control.

- Two complaints related to resident care not being completed and staffing levels in the home.

- One complaint related to resident care concerns and the staffing levels in the home. A Critical Incident System intake, related to the same issue, was also inspected during this Complaint inspection.

A Critical Incident inspection #2019_657681_0027, was conducted concurrently with this inspection.

Inspector, Keara Cronin (#759), was present throughout the inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, former Director of Care (DOC), Interim Dietary Manager, Environmental Services Manager, Registered Dietitian, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Physiotherapy Assistant (PTA), Housekeeping staff, family members, and residents.

The Inspectors also conducted a tour of the resident care areas, reviewed relevant resident care records, home investigation notes, home policies and observed resident rooms, resident common areas, and the delivery of resident care and services, including staff to resident interactions.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Continence Care and Bowel Management
Food Quality
Infection Prevention and Control
Nutrition and Hydration
Personal Support Services
Reporting and Complaints
Skin and Wound Care
Sufficient Staffing

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

- **9 WN(s)**
- **3 VPC(s)**
- **5 CO(s)**
- **1 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. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and 2007, c. 8, s. 8 (1).
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of nursing services and personal support services for the home that met the assessed needs of the residents.

Complaints were submitted to the Director related to residents not receiving baths due to short staffing.

a) Through record reviews and interviews with Staff Members #115 and #119, it was identified that resident #001 missed their scheduled bathing option on four specified dates in September 2019, due to short staffing. Please refer to WN #2, Finding #1 for further details.

Inspector #681 reviewed the home's "Staffing Plan Policy for Nursing & Personal Support Services Program", effective March 2019, which indicated that the home's staffing plan must provide for a staffing mix that was consistent with the residents' assessed care and safety needs. The staffing plan indicated the home's base staffing compliment for RPNs and PSWs on day and evening shift on the various units.

During an interview with Staff Member #105, they stated that the home's staffing plan had changed and the number of registered staff on the units had increased. Staff Member #105 stated that RPN staff were now required to complete personal care, as well as, registered staff duties.

The Inspector compared the home's staffing plan to the actual hours worked for RPNs and PSWs and identified that, on each of the four dates that resident #002 did not receive their scheduled bathing option, the home was short between 2.0 and 3.0 full time equivalent PSW or RPN staff.

b) Through record reviews and interviews with Staff Members #103 and #104, it was identified that resident #003 had not received their preferred bathing option for 18 consecutive days. Resident #003 should have received their preferred bathing option four times in the 18 day period. Please refer to WN #2, Finding #2 for further details.

The Inspector compared the home's staffing plan to the actual hours worked for RPN and PSW staff. The Inspector identified that, for three of the dates when resident #003 did not receive their scheduled bathing option, the home was short 3.0 full time equivalent PSW

or RPN staff and, on the fourth specified date, the home was short 1.0 full time equivalent PSW or RPN.

c) Through record reviews and interviews with Staff Members #103 and #104, it was identified that resident #004 missed their preferred bathing option on four specified dates in September 2019, due to short staffing. Please refer to WN #2, Finding #3 for further details.

The Inspector compared the home's staffing plan to the actual hours worked for RPNs and PSWs and identified that, on each of the four specified dates when resident #002 did not receive their scheduled bathing option, the home was short between 1.0 and 4.0 full time equivalent PSWs or RPNs.

2. Complaints were submitted to the Director, related to residents not receiving meals and snacks due to short staffing. Please refer to WN #4 for additional details.

a) Through record reviews and an interview with Staff Member #104, it was identified that resident #007 was not offered a specified meal and nourishment on a particular date in September 2019, because of insufficient staffing.

The Inspector compared the home's staffing plan to actual hours worked for RPN and PSW staff for the particular date, and identified that the home was short 5.0 full time equivalent PSW or RPN staff on this date.

b) Through record reviews and interviews with Staff Members #112 and #114, it was identified that nourishment carts had not been completed on nine separate occasions during the month of September 2019.

The Inspector compared the home's staffing plan to actual hours worked for RPNs and PSWs and identified that, for the shifts where the nourishment carts were not completed, the home was short between 3.0 and 5.0 full time equivalent PSW or RPN staff.

3. A complaint was submitted to the Director, related to resident personal care not being completed, resulting in skin breakdown. The complainant also identified that wound assessments were not being completed.

Through record reviews and interviews with Staff Members #113, #116, and #119, it was identified that assessments were not completed for resident #008's altered skin integrity

on two specified dates in September 2019, because of short staffing.

Please refer to WN #3, Finding #3 for additional details.

The Inspector compared the home's staffing plan to actual hours worked for RPNs and PSWs and identified that, on the two specified dates, the home was short 3.0 full time equivalent PSWs or RPNs.

During an interview with the former DOC (DOC #122), they stated that the home was struggling to fully staff some of the PSW and RPN shifts and that the units had been working with fewer staff than what was identified in the home's staffing plan on a day to day basis.

During an interview with the Administrator, they advised the Inspector that the home's staffing plan had recently changed and that the home had moved to a registered staff model. The Administrator stated that the home had increased the number of registered staff on the units and decreased the number of PSWs. The Administrator stated that some staff at the home were struggling with realigning their duties under the new staffing model and that some registered staff did not want to complete personal care. The Administrator also stated that when the home was working short, certain care was prioritized and this included feeding, continence, medication administration, wound dressings, and nourishments. [s. 8 (1) (a)] [s. 8. (1) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector". DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week, by the method of their choice.

Complaints were submitted to the Director related to residents not receiving baths due to short staffing.

Inspector #681 reviewed resident #001's care plan, which indicated that the resident was to receive their preferred bathing option on two days each week.

Inspector #749 reviewed the progress notes in resident #001's electronic medical record and identified progress notes entered on three specified dates in September 2019, which indicated that resident #001 had not received their preferred bathing option on these dates because of staffing shortages.

During an interview with Inspector #749, resident #001 stated that they sometimes did not receive their preferred bathing option because the unit was short staffed.

During an interview with Inspector #681, Staff Member #115 stated that resident #001 was supposed to receive their preferred bathing option twice per week. The Staff Member reviewed the documentation on resident #001's Bath Flow Sheet and stated that resident #001 missed their preferred bathing option on three specified dates in September 2019. Staff member #115 stated that when the unit was short staffed, baths were usually not completed.

During an interview with Inspector #681, Staff Member #119 stated that it was possible that resident #001 had gone 10 consecutive days without receiving their preferred bathing option and this was reflective of what had been occurring on the unit with regards to bathing. Staff Member #119 stated that they were aware of another resident, who resided in the same hallway as resident #001, who had also missed receiving their

preferred bathing option three times in a row due to short staffing.

2. Inspector #681 reviewed resident #003's care plan, which indicated that the resident was to receive their preferred bathing option two days per week.

Inspector #681 was unable to locate any documentation to support that resident #003 had received their preferred bathing option within the past 18 days.

During an interview with Staff Member #104, they stated that resident #003 was to receive their preferred bathing option two days per week. Staff member #104 reviewed the Bath Flow Sheets and stated that the resident last received their preferred bathing option 18 days ago. The staff member indicated that this was reflective of what had been occurring on the unit and that baths were not being completed because of short staffing.

During an interview with Staff Member #103, they stated that some residents on the unit had not been bathed in a while because of short staffing.

3. Inspector #681 reviewed resident #004's care plan, which indicated that the resident was to received their preferred bathing option on two specified days each week.

Inspector #681 reviewed resident #004's Bath Flow Sheet, which indicated that the resident missed their scheduled bathing option on four specified dates in September 2019.

During an interview with Staff Member #104, they stated that resident #004 was to receive their preferred bathing option on two specified dates each week. Staff member #104 reviewed the Bath Flow Sheets and verified that resident #004 missed their bathing option on four dates in September 2019. The staff member indicated that this was reflective of what had been occurring on the unit and that there was not enough staff to complete the required care.

During an interview with the DOC, they stated that they were aware that baths had been missed and that some baths may have been missed because staff did not believe that there was an appropriate number of staff on the unit to provide the care. The DOC stated that sometimes a bed bath was being completed in place of a resident's preferred bathing option. The DOC also stated that they had not participated in rescheduling missed baths or showers, nor were they aware of the duration of time that some residents had gone without a bath or shower.

During an interview with the Administrator, they stated that they were aware that baths were being missed, but they were uncertain about whether missed baths were being rescheduled or made up. [s. 33. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that when resident #001 exhibited altered skin integrity, the resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

A complaint and Critical Incident System (CIS) report were submitted to the Director related to resident #001 not receiving continence care as per the resident's plan of care.

Inspector #749 reviewed resident #001's electronic progress notes and the home's investigation notes related to the critical incident, which both indicated that the resident had a new area of altered skin integrity.

Inspector #749 reviewed resident #001's electronic health record and was unable to locate an assessment for the new area of altered skin integrity that had been identified.

The Inspector reviewed the home's policy titled "Skin & Wound Management Program", effective March 2019. The policy indicated that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds should receive an assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designated for skin and wound assessment.

The Inspector interviewed DOC #122 and inquired about whether the new area of altered skin integrity had been assessed by the nursing staff. DOC #122 verified that resident #001 had a new area of altered skin integrity and stated that registered staff did not document their assessment related to the new area of altered skin integrity. [50. (2) (b) (i)]

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A complaint and CIS report were submitted to the Director related to resident #001 not receiving continence care as per the resident's plan of care.

During an interview with resident #001, they stated that they had an area of altered skin integrity.

Inspector #749 reviewed resident #001's current electronic care plan, which identified that resident #001 had an area of altered skin integrity and that staff were to complete a weekly assessment.

The Inspector reviewed resident #001's treatment administration record (TAR), which indicated that the resident's area of altered skin integrity was to be monitored and a weekly progress note was to be completed.

The Inspector reviewed resident #001's electronic progress notes and was unable to

locate weekly progress notes for four dates in August 2019 and four dates in September 2019.

The Inspector reviewed the home's policy titled "Skin & Wound Management Program", effective March 2019, which identified that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was to be reassessed weekly, if indicated.

Inspector #749 interviewed DOC #122, who verified that resident #001's TAR indicated to monitor the area of altered skin integrity and to complete a weekly progress note. Together, Inspector#749 and DOC #122 reviewed the electronic progress notes for resident #001 and DOC #122 verified that progress notes were not completed as per the TAR and that they would follow up with staff about not following the home's skin and wound management policy.

3. A complaint was submitted to the Director related to personal care not being completed, which resulted in skin breakdown. The complainant also identified that wound assessments were not being completed.

Inspector #681 reviewed resident #008's TAR, which indicated that weekly assessments were to be completed related to resident #008's altered skin integrity.

The Inspector reviewed the assessments in resident #008's electronic medical record and identified that two consecutive weekly assessments had not been completed.

During an interview with Staff Member #116, they verified that resident #008 did not have wound assessments completed for two specified weeks in September 2019.

During an interview with Staff Member #119, they stated that skin and wound assessments were not consistently being done because of short staffing.

During an interview with DOC #122, they stated that RPNs were responsible for completing assessments for areas of altered skin integrity; however, they were uncertain about the frequency at which altered skin integrity assessments had to be completed because "everyone [was] different". DOC #122 stated that they would have to review the home's policy.

During an interview with the Administrator, they stated that the Director of Care was the

Skin and Wound Lead for the home. The Administrator stated that they were uncertain about the frequency at which altered skin integrity assessments were to be completed and it be would be "whatever [was] in the policy". The Administrator stated that, as a registered provider, staff completed an assessment every time a treatment was done, but that this assessment may not be documented in the resident's chart as per the requirements in the Long-Term Care Homes Act and the home's policy.

4. Inspector #681 reviewed resident #009's TAR, which indicated that weekly assessments were to be completed for areas of altered skin integrity.

The Inspector reviewed resident #009's electronic medical record and was unable to locate weekly assessments for resident #009's areas of altered skin integrity.

During an interview with Staff Member #116, they stated that resident #009's TAR indicated that weekly assessments were to be completed for resident #009's areas of altered skin integrity. Staff Member #116 reviewed the progress notes and assessments in resident #009's electronic medical record and stated that resident #009's areas of altered skin integrity were last assessed eight months prior to the start of the inspection.

During an interview with Staff Member #112, they stated that resident #009 had areas of altered skin integrity. Staff Member #112 stated that they were to assess the areas of altered skin integrity each week, but that this was not always completed because of insufficient time.

The Inspector reviewed resident #009's TAR with the Administrator, who stated that weekly assessments should have been completed on resident #009's areas of altered skin integrity. The Administrator stated that, although formal assessments may not have been completed or documented, registered staff would have assessed the areas of altered skin integrity every time they completed a specified treatment intervention. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

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. (3) The licensee shall ensure that each resident is offered a minimum of, (b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of, (c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was offered a minimum of three meals daily; a beverage in the morning, afternoon, and evening; and a snack in the afternoon and evening.

Complaints were submitted to the Director related to residents not receiving meals and snacks due to short staffing.

Inspector #681 reviewed the Food and Fluid consumption sheet for a specified unit, and identified that a zero was documented at a meal for resident #007, on a specified date in September 2019. The Food and Fluid consumption sheet also indicated that the nourishment cart had not been done on the same specified date, due to short staffing.

The Inspector reviewed resident #007's current care plan, which indicated that resident #007 was to receive specified nutrition interventions at meals and snacks.

During an interview with Staff Member #104, they stated that the unit was short staffed on the particular date and that staff made the decision not to assist resident #007 for a specified meal. Staff Member #104 confirmed that one of the nourishment carts was also not done on the same specified date. [s. 71. (3) (a)]

2. Inspector #681 reviewed the Food and Fluid binders on two specified units and identified that nourishment carts had not been completed on nine separate occasions during the month of September 2019.

During separate interviews with Staff Members #112 and #114, they stated that nourishment carts were not always completed because of short staffing.

During an interview with DOC #122, they stated that they were unaware of residents not being assisted with meals, but were aware of instances when nourishment carts had not gone out. However, DOC #122 stated that they did not know the reasons why the nourishment carts were not always being completed. [s. 71. (3) (b)] [s. 71. (3) (c)]

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. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector; O. Reg. 79/10, s. 213 (4).
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and O. Reg. 79/10, s. 213 (4).
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care had at least one year of experience working as a registered nurse in the long-term care sector.

A complaint was submitted to the Director, regarding the qualifications and past work experience of the DOC.

Upon entering the home, the Administrator advised the Inspectors that DOC #122 had resigned from their position as DOC and that the position was being covered by the Administrator until a new DOC started. Please refer to WN #8 for further details.

Inspector #690 reviewed DOC #122's resume and identified that DOC #122 did not have any previous employment experience in long-term care.

In an interview with Inspector #690, DOC #122 indicated that they had accepted the position of DOC on a specific date and had resigned from the position in September 2019. DOC #122 indicated that, prior to their position of DOC at Belvedere Heights, they did not have any previous experience working in long-term care.

During an interview with the Administrator, they stated that DOC #122 started in the position of DOC on a specific date. The Administrator stated that they were aware that DOC #122 did not have the required qualifications when they hired them. [s. 213. (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 LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the residents.

A complaint was submitted to the Director related to personal care not being completed, resulting in skin breakdown. The complainant also identified that wound assessments were not being completed. Please refer to WN #3, Finding #4 for further details.

Inspector #681 reviewed resident #009's TAR, which indicated that resident #009 was to receive a specified treatment intervention for their altered skin integrity.

The Inspector reviewed the "Prescriber's Order Review" from resident #009's paper chart, which indicated that resident #009 was to receive a different treatment intervention for altered skin integrity than what was identified in resident #009's TAR.

During an interview with Staff Member #112, they stated that resident #009 had areas of altered skin integrity. Staff Member #112 stated that staff were completing another treatment intervention, which was different than what was in the TAR or on the Prescriber's Order Review.

The Inspector reviewed resident #009's TAR and Prescriber's Order Review with the Administrator, who stated that the Prescriber's Order Review was generated from the last physician order so this would reflect the most recent treatment order. The Administrator

stated that the TAR should match the most recent physician order. The Administrator acknowledged that staff would be completing treatments based on the information in the TAR and, if there was a question, then staff would look at the order for clarification.

2. A complaint and CIS report were submitted to the Director, related to staff not providing continence care to resident #001 as per the resident's plan of care. Please refer to WN #3, Findings #1 and #2 for further details.

Inspector #749 reviewed resident #001's care plan and identified that the care plan contained contradictory information regarding the level of assistance that resident #001 required to complete a particular activity.

Together, Inspector #749 and DOC #122 reviewed resident #001's care plan. DOC #122 acknowledged that the different foci of resident #001's care plan did not provide clear direction to staff. [s. 6. (1) (c)]

3. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Complaints were submitted to the Director related to residents not receiving baths due to short staffing. Please refer to WN #2, Finding #1 for further details.

During an interview with Inspector #749, resident #001 stated that they were to receive their preferred bathing option twice per week. Resident #001 stated that they had received their preferred bathing option on a specified date in September 2019.

Inspector #681 reviewed resident #001's Bath Flow Sheet and was unable to locate documentation related to the completion of resident #001's preferred bathing option on the specified date.

During an interview with Staff Member #119, they verified that resident #001 received their preferred bathing option on the specified date in September 2019, but that it was not documented by staff.

4. A complaint was submitted to the Director related to personal care not being completed, which resulted in skin breakdown. Please refer to WN #3, Finding #3 for additional details.

Inspector #681 reviewed resident #008's TAR, which indicated that the resident was to have treatments completed for their altered skin integrity. Resident #008's TAR indicated that resident #008's treatments were "scheduled" but not completed for two specified dates.

During an interview with Staff Member #119, they stated that they completed resident #008's treatments on the specified dates, but that they did not document the completion of the treatments in the TAR.

5. A complaint and CIS report were submitted to the Director related to staff not providing continence care to resident #001 as per the resident's plan of care. Please refer to WN #3, Findings #1 and #2 for additional details.

Inspector #749 reviewed resident #001's TAR and identified an active treatment that was to be completed.

The Inspector identified that treatments had not been signed as completed in the TAR and were still marked as "scheduled" for three specified dates in August 2019, and four specified dates in September 2019.

Inspector #681 interviewed Staff Member #116, who indicated that treatments were documented in the TAR and the TAR should indicate "given" once a treatment had been completed.

Together, Inspector #749 and DOC #122 reviewed resident #001's TAR for the months of August and September 2019. DOC #122 verified that the treatments were still identified as "scheduled" for the three specified dates in August 2019 and the four specified dates in September 2019. (749) [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident; and that provision of the care set out in the plan of care is documented, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure was complied with.

In accordance with Ontario Regulation 79/10, s. 87 (2) (a), the licensee was required to ensure that procedures were developed and implemented for the cleaning of the home, including resident bedrooms.

Specifically, staff did not comply with the licensee's policy regarding "Deep Cleaning Resident Rooms" (Hous-1076) with an effective date of December 2010, which was part of the home's housekeeping policies and procedures.

A complaint was submitted to the Director regarding housekeeping and the cleanliness of

the home.

During an interview with Staff Member #110, they stated that housekeeping staff had not been doing full cleans (or "PULLS") of resident rooms because of short staffing. Staff Member #110 stated that the home started a schedule of full cleans in the Spring of 2019, and that full cleans were documented on a tracking sheet.

Inspector #681 reviewed the home's policy titled "Deep Cleaning Resident Rooms" (Hous-1076), which indicated that all resident rooms were to be deep cleaned every five to six weeks.

The Inspector reviewed documentation from the Full Cleans completed on different units and identified the following:

- On one unit, 35 out of 37 (or 95 per cent) of resident rooms had not had a full clean completed within the six weeks proceeding the start of the inspection.
- On another unit, none of the resident rooms had a full clean completed within the six weeks proceeding the start of the inspection.
- On a different unit, only two resident rooms had a full clean completed within the six weeks proceeding the start of the inspection.

During an interview with the Environmental Services Manager, they stated that full cleans were to be completed every four to six weeks, as per the home's policy. The Environmental Services Manager also stated that the housekeeping department had been short staffed and that some days the home was working with only 50 per cent of the scheduled housekeeping staff compliment present. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any procedure, the procedure was complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 71. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the long-term care home has a Director of Nursing and Personal Care. 2007, c. 8, s. 71. (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the long-term care home had a Director of Nursing and Personal Care.

Upon entering the home, the Administrator advised the Inspectors that DOC #122 had resigned from their position as DOC and that the position was being covered by the Administrator until a new DOC started in October 2019.

In an interview with Inspector #690, DOC #122 indicated that they accepted the position of DOC on a specific date, and had resigned from the position during September 2019.

In an Interview with Inspector #690, the Administrator indicated that they were covering the role as DOC and Administrator until the new DOC started their position in October 2019. The Administrator further acknowledged that the home was required to have a Administrator for 35 hours per week, as well as, a DOC for 35 hours per week, and that the home was not meeting that requirement. (690) [s. 71. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the long-term care home has a Director of Nursing and Personal Care, to be implemented voluntarily.

WN #9: 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 reportable disease or communicable disease as defined in the Health Protection and Promotion Act. O. Reg. 79/10, s. 107 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the Director was immediately informed of an outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

A complaint was submitted to the Director related to Infection Prevention and Control procedures.

Upon entering the home, Inspector #690 observed signage in the hallway on the main floor, which indicated that the home was in a facility wide respiratory outbreak.

The Inspector reviewed the "Institutional Outbreak Line Listing Record", which indicated that the respiratory outbreak was initiated on a specific date in September 2019.

A review of the home's policy titled "Critical Incident Reporting-NRG-501", effective November 2012, indicated that the home was to immediately inform the Director in as much detail as was possible in the circumstance of any outbreak of a reportable disease or communicable disease as defined in the Health Protection and Promotion Act.

In an interview with Inspector #690, DOC #122 indicated that the home had been declared in a respiratory outbreak on a specific date in September 2019. DOC #122 indicated that they were aware of the requirement to report the disease outbreak to the Director immediately and that they had forgotten to do so.

In an interview with Administrator, they indicated that DOC #122 was supposed to have reported the disease outbreak to the Director on the day that the outbreak was declared. The Administrator viewed the Long Term Care Homes Portal and indicated to the Inspector that there had been no CIS report submitted for the disease outbreak and that there should have been. [s. 107. (1) 5.]

Issued on this 6th day of November, 2019

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	STEPHANIE DONI (681), AMY PAGE (749), TRACY MUCHMAKER (690)
Inspection No. / No de l'inspection :	2019_657681_0026
Log No. / No de registre :	016777-19, 016960-19, 016973-19, 017627-19, 017634-19, 018292-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 4, 2019
Licensee / Titulaire de permis :	Board of Management for the District of Parry Sound West 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
LTC Home / Foyer de SLD :	Belvedere Heights 21 Belvedere Avenue, PARRY SOUND, ON, P2A-2A2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marsha Rivers

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To Board of Management for the District of Parry Sound West, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (1) (a) (b) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nursing services for the home to meet the assessed needs of the residents; and
(b) an organized program of personal support services for the home to meet the assessed needs of the residents. 2007, c. 8, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8 (1) (b) of the LTCHA, 2007.

The licensee shall prepare, submit, and implement a plan to ensure that the home's organized program of nursing services and organized program of personal support services meets the assessed needs of the residents.

The plan must include, but is not limited to, the following:

a) How the management of the home will complete a time analysis study of the residents' assessed care needs for each of the home's units in collaboration with a PSW and a RPN who regularly work on that unit. Documentation of the time analysis study and who participated in the study must be maintained.

b) How the home will review and revise the staffing plan to ensure that the assessed care needs of residents are met.

c) How the home will ensure that any missed care is documented, rescheduled, and completed.

Grounds / Motifs :

1. The licensee has failed to ensure that there was an organized program of nursing services and personal support services for the home that met the assessed needs of the residents.

Complaints were submitted to the Director related to residents not receiving baths due to short staffing.

a) Through record reviews and interviews with Staff Members #115 and #119, it was identified that resident #001 missed their scheduled bathing option on four specified dates in September 2019, due to short staffing. Please refer to WN #2, Finding #1 for further details.

Inspector #681 reviewed the home's "Staffing Plan Policy for Nursing & Personal Support Services Program", effective March 2019, which indicated that the home's staffing plan must provide for a staffing mix that was consistent with the residents' assessed care and safety needs. The staffing plan indicated the home's base staffing compliment for RPNs and PSWs on day and evening shift on the various units.

During an interview with Staff Member #105, they stated that the home's staffing plan had changed and the number of registered staff on the units had increased. Staff Member #105 stated that RPN staff were now required to complete personal care, as well as, registered staff duties.

The Inspector compared the home's staffing plan to the actual hours worked for RPNs and PSWs and identified that, on each of the four dates that resident #002 did not receive their scheduled bathing option, the home was short between 2.0 and 3.0 full time equivalent PSW or RPN staff.

b) Through record reviews and interviews with Staff Members #103 and #104, it was identified that resident #003 had not received their preferred bathing option for 18 consecutive days. Resident #003 should have received their preferred bathing option four times in the 18 day period. Please refer to WN #2, Finding #2 for further details.

The Inspector compared the home's staffing plan to the actual hours worked for RPN and PSW staff. The Inspector identified that, for three of the dates when resident #003 did not receive their scheduled bathing option, the home was short 3.0 full time equivalent PSW or RPN staff and, on the fourth specified date, the home was short 1.0 full time equivalent PSW or RPN.

c) Through record reviews and interviews with Staff Members #103 and #104, it was identified that resident #004 missed their preferred bathing option on four specified dates in September 2019, due to of short staffing. Please refer to WN #2, Finding #3 for further details.

The Inspector compared the home's staffing plan to the actual hours worked for RPNs and PSWs and identified that, on each of the four specified dates when resident #002 did not receive their scheduled bathing option, the home was short between 1.0 and 4.0 full time equivalent PSWs or RPNs.

2. Complaints were submitted to the Director, related to residents not receiving meals and snacks due to short staffing. Please refer to WN #4 for additional details.

a) Through record reviews and an interview with Staff Member #104, it was identified that resident #007 was not offered a specified meal and nourishment on a particular date in September 2019, because of insufficient staffing.

The Inspector compared the home's staffing plan to actual hours worked for RPN and PSW staff for the particular date, and identified that the home was short 5.0 full time equivalent PSW or RPN staff on this date.

b) Through record reviews and interviews with Staff Members #112 and #114, it was identified that nourishment carts had not been completed on nine separate occasions during the month of September 2019.

The Inspector compared the home's staffing plan to actual hours worked for RPNs and PSWs and identified that, for the shifts where the nourishment carts were not completed, the home was short between 3.0 and 5.0 full time equivalent PSW or RPN staff.

3. A complaint was submitted to the Director, related to resident personal care not being completed, resulting in skin breakdown. The complainant also identified that wound assessments were not being completed.

Through record reviews and interviews with Staff Members #113, #116, and

#119, it was identified that assessments were not completed for resident #008's altered skin integrity on two specified dates in September 2019, because of short staffing.

Please refer to WN #3, Finding #3 for additional details.

The Inspector compared the home's staffing plan to actual hours worked for RPNs and PSWs and identified that, on the two specified dates, the home was short 3.0 full time equivalent PSWs or RPNs.

During an interview with the former DOC (DOC #122), they stated that the home was struggling to fully staff some of the PSW and RPN shifts and that the units had been working with fewer staff than what was identified in the home's staffing plan on a day to day basis.

During an interview with the Administrator, they advised the Inspector that the home's staffing plan had recently changed and that the home had moved to a registered staff model. The Administrator stated that the home had increased the number of registered staff on the units and decreased the number of PSWs. The Administrator stated that some staff at the home were struggling with realigning their duties under the new staffing model and that some registered staff did not want to complete personal care. The Administrator also stated that when the home was working short, certain care was prioritized and this included feeding, continence, medication administration, wound dressings, and nourishments.

The severity of this issue was determined to be a level three, as there was actual harm or actual risk to the residents of the home. The scope of the issue was a level three, as it was identified to be a widespread issue, affecting six out of the six residents who were reviewed. The home had a level two compliance history, as they had no previous non-compliance with this section of the LTCHA. (681)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Feb 03, 2020

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 33 (1) of the Ontario Regulation 79/10.

The licensee shall prepare, submit, and implement a plan to ensure that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice.

The plan must include, but is not limited to, the following:

a) How the licensee will ensure that all residents, including those who require the assistance of two staff, are bathed at a minimum of twice a week using a method of their choice.

b) How the licensee will develop and implement a process to ensure that documentation is maintained if a resident's bath or shower is not completed, or if a resident is bathed using a method other than their preferred choice.

c) How the licensee will ensure that the home's Director of Care and/or Administrator are involved in monitoring and rescheduling any missed baths or showers.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week, by the method of their choice.

Complaints were submitted to the Director related to residents not receiving

baths due to short staffing.

Inspector #681 reviewed resident #001's care plan, which indicated that the resident was to receive their preferred bathing option on two days each week.

Inspector #749 reviewed the progress notes in resident #001's electronic medical record and identified progress notes entered on three specified dates in September 2019, which indicated that resident #001 had not received their preferred bathing option on these dates because of staffing shortages.

During an interview with Inspector #749, resident #001 stated that they sometimes did not receive their preferred bathing option because the unit was short staffed.

During an interview with Inspector #681, Staff Member #115 stated that resident #001 was supposed to receive their preferred bathing option twice per week. The Staff Member reviewed the documentation on resident #001's Bath Flow Sheet and stated that resident #001 missed their preferred bathing option on three specified dates in September 2019. Staff member #115 stated that when the unit was short staffed, baths were usually not completed.

During an interview with Inspector #681, Staff Member #119 stated that it was possible that resident #001 had gone 10 consecutive days without receiving their preferred bathing option and this was reflective of what had been occurring on the unit with regards to bathing. Staff Member #119 stated that they were aware of another resident, who resided in the same hallway as resident #001, who had also missed receiving their preferred bathing option three times in a row due to short staffing.

2. Inspector #681 reviewed resident #003's care plan, which indicated that the resident was to receive their preferred bathing option two days per week.

Inspector #681 was unable to locate any documentation to support that resident #003 had received their preferred bathing option within the past 18 days.

During an interview with Staff Member #104, they stated that resident #003 was to receive their preferred bathing option two days per week. Staff member #104

reviewed the Bath Flow Sheets and stated that the resident last received their preferred bathing option 18 days ago. The staff member indicated that this was reflective of what had been occurring on the unit and that baths were not being completed because of short staffing.

During an interview with Staff Member #103, they stated that some residents on the unit had not been bathed in a while because of short staffing.

3. Inspector #681 reviewed resident #004's care plan, which indicated that the resident was to received their preferred bathing option on two specified days each week.

Inspector #681 reviewed resident #004's Bath Flow Sheet, which indicated that the resident missed their scheduled bathing option on four specified dates in September 2019.

During an interview with Staff Member #104, they stated that resident #004 was to receive their preferred bathing option on two specified dates each week. Staff member #104 reviewed the Bath Flow Sheets and verified that resident #004 missed their bathing option on four dates in September 2019. The staff member indicated that this was reflective of what had been occurring on the unit and that there was not enough staff to complete the required care.

During an interview with the DOC, they stated that they were aware that baths had been missed and that some baths may have been missed because staff did not believe that there was an appropriate number of staff on the unit to provide the care. The DOC stated that sometimes a bed bath was being completed in place of a resident's preferred bathing option. The DOC also stated that they had not participated in rescheduling missed baths or showers, nor were they aware of the duration of time that some residents had gone without a bath or shower.

During an interview with the Administrator, they stated that they were aware that baths were being missed, but they were uncertain about whether missed baths were being rescheduled or made up.

The severity of this issue was determined to be a level two, as there was minimal harm or minimal risk to the residents of the home. The scope of the

issue was a level three, as it related to three out of three residents who were reviewed. The home had a level two compliance history, as they had no previous non-compliance with this section of the Ontario Regulation 79/10. (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 23, 2019

Order # / Ordre no : 003

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

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 must be compliant with s. 50 (2) (b) of the Ontario Regulation 79/10.

The licensee shall prepare, submit, and implement a plan to ensure that each resident of the home with altered skin integrity is assessed by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessments, and that each resident is reassessed at least weekly, if clinically indicated.

The plan must include, but is not limited to, the following:

a) How the licensee will ensure that all residents with altered skin integrity receive an assessment by a member of the registered nursing staff, using a clinically appropriate assessment tool, and that these assessments are consistently documented in a specified location.

b) How the licensee will ensure that all residents with altered skin integrity are reassessed weekly, if clinically indicated, by a member of the registered nursing staff.

c) How the licensee will educate registered staff on process for completing skin and wound assessments and the actions to be taken if an area of altered skin integrity worsens.

d) How the licensee will develop and implement an auditing tool to ensure that skin and wound assessments are being completed as per the home's policy. A record of the audits must be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that when resident #001 exhibited altered skin integrity, the resident received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessments.

A complaint and Critical Incident System (CIS) report were submitted to the Director related to resident #001 not receiving continence care as per the resident's plan of care.

Inspector #749 reviewed resident #001's electronic progress notes and the home's investigation notes related to the critical incident, which both indicated that the resident had a new area of altered skin integrity.

Inspector #749 reviewed resident #001's electronic health record and was unable to locate an assessment for the new area of altered skin integrity that had been identified.

The Inspector reviewed the home's policy titled "Skin & Wound Management Program", effective March 2019. The policy indicated that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds should receive an assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designated for skin and wound assessment.

The Inspector interviewed DOC #122 and inquired about whether the new area of altered skin integrity had been assessed by the nursing staff. DOC #122 verified that resident #001 had a new area of altered skin integrity and stated that registered staff did not document their assessment related to the new area of altered skin integrity. (749)

2. The licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff.

A complaint and CIS report were submitted to the Director related to resident #001 not receiving continence care as per the resident's plan of care.

During an interview with resident #001, they stated that they had an area of altered skin integrity.

Inspector #749 reviewed resident #001's current electronic care plan, which identified that resident #001 had an area of altered skin integrity and that staff were to complete a weekly assessment.

The Inspector reviewed resident #001's treatment administration record (TAR),

which indicated that the resident's area of altered skin integrity was to be monitored and a weekly progress note was to be completed.

The Inspector reviewed resident #001's electronic progress notes and was unable to locate weekly progress notes for four dates in August 2019 and four dates in September 2019.

The Inspector reviewed the home's policy titled "Skin & Wound Management Program", effective March 2019, which identified that any resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was to be reassessed weekly, if indicated.

Inspector #749 interviewed DOC #122, who verified that resident #001's TAR indicated to monitor the area of altered skin integrity and to complete a weekly progress note. Together, Inspector#749 and DOC #122 reviewed the electronic progress notes for resident #001 and DOC #122 verified that progress notes were not completed as per the TAR and that they would follow up with staff about not following the home's skin and wound management policy. (681)

3. A complaint was submitted to the Director related to personal care not being completed, which resulted in skin breakdown. The complainant also identified that wound assessments were not being completed.

Inspector #681 reviewed resident #008's TAR, which indicated that weekly assessments were to be completed related to resident #008's altered skin integrity.

The Inspector reviewed the assessments in resident #008's electronic medical record and identified that two consecutive weekly assessments had not been completed.

During an interview with Staff Member #116, they verified that resident #008 did not have wound assessments completed for two specified weeks in September 2019.

During an interview with Staff Member #119, they stated that skin and wound assessments were not consistently being done because of short staffing.

During an interview with DOC #122, they stated that RPNs were responsible for completing assessments for areas of altered skin integrity; however, they were uncertain about the frequency at which altered skin integrity assessments had to be completed because "everyone [was] different". DOC #122 stated that they would have to review the home's policy.

During an interview with the Administrator, they stated that the Director of Care was the Skin and Wound Lead for the home. The Administrator stated that they were uncertain about the frequency at which altered skin integrity assessments were to be completed and it be would be "whatever [was] in the policy". The Administrator stated that, as a registered provider, staff completed an assessment every time a treatment was done, but that this assessment may not be documented in the resident's chart as per the requirements in the Long-Term Care Homes Act and the home's policy. (681)

4. Inspector #681 reviewed resident #009's TAR, which indicated that weekly assessments were to be completed for areas of altered skin integrity.

The Inspector reviewed resident #009's electronic medical record and was unable to locate weekly assessments for resident #009's areas of altered skin integrity.

During an interview with Staff Member #116, they stated that resident #009's TAR indicated that weekly assessments were to be completed for resident #009's areas of altered skin integrity. Staff Member #116 reviewed the progress notes and assessments in resident #009's electronic medical record and stated that resident #009's areas of altered skin integrity were last assessed eight months prior to the start of the inspection.

During an interview with Staff Member #112, they stated that resident #009 had areas of altered skin integrity. Staff Member #112 stated that they were to assess the areas of altered skin integrity each week, but that this was not always completed because of insufficient time.

The Inspector reviewed resident #009's TAR with the Administrator, who stated that weekly assessments should have been completed on resident #009's areas

of altered skin integrity. The Administrator stated that, although formal assessments may not have been completed or documented, registered staff would have assessed the areas of altered skin integrity every time they completed a specified treatment intervention.

The severity of this issue was determined to be a level three, as there was actual harm or actual risk to the residents of the home. The scope of the issue was a level three, as it related to three of three residents reviewed. The home had a level three compliance history, as they had related non-compliance with this section of the Ontario Regulation that included:

- a compliance order (CO) issued December 21, 2016, with a compliance due date of January 20, 2017 (#2016_332575_0021);

- a voluntary plan of correction (VPC) issued September 12, 2018 (#2018_745690_0008). (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 23, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et 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 # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee must be compliant with s. 71 (3) of the Ontario Regulation 79/10.

The licensee shall prepare, submit, and implement a plan to ensure that each resident of the home is offered a minimum of three meals per day; a between meal beverage in the morning, afternoon, and evening; and a snack in the afternoon and evening.

The plan must include, but is not limited to, the following:

a) How the licensee will ensure that resident #007, and all other residents, are offered three meals per day.

b) How the licensee will ensure all residents are offered a beverage in the morning, afternoon, and evening, and a snack in the afternoon and evening.

c) How the home's management team will be involved in conducting audits to ensure that all residents are offered their meals and snacks. A record of the audits must be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident was offered a minimum of three meals daily; a beverage in the morning, afternoon, and evening; and a snack in the afternoon and evening.

Complaints were submitted to the Director related to residents not receiving meals and snacks due to short staffing.

Inspector #681 reviewed the Food and Fluid consumption sheet for a specified unit, and identified that a zero was documented at a meal for resident #007, on a specified date in September 2019. The Food and Fluid consumption sheet also indicated that the nourishment cart had not been done on the same specified date, due to short staffing.

The Inspector reviewed resident #007's current care plan, which indicated that resident #007 was to receive specified nutrition interventions at meals and snacks.

During an interview with Staff Member #104, they stated that the unit was short staffed on the particular date and that staff made the decision not to assist resident #007 for a specified meal. Staff Member #104 confirmed that one of the nourishment carts was also not done on the same specified date. (681)

2. Inspector #681 reviewed the Food and Fluid binders on two specified units and identified that nourishment carts had not been completed on nine separate occasions during the month of September 2019.

During separate interviews with Staff Members #112 and #114, they stated that nourishment carts were not always completed because of short staffing.

During an interview with DOC #122, they stated that they were unaware of residents not being assisted with meals, but were aware of instances when nourishment carts had not gone out. However, DOC #122 stated that they did not know the reasons why the nourishment carts were not always being completed.

The severity of this issue was determined to be a level three, as there was actual harm or actual risk to the residents of the home. The scope of the issue was a level two, as it was related to two out of the three units in the home. The home had a level two compliance history, as they had no previous non-compliance with this section of the Ontario Regulation. (681)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Dec 16, 2019

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 213. (4) The licensee shall ensure that everyone hired as a Director of Nursing and Personal Care after the coming into force of this section,
(a) has at least one year of experience working as a registered nurse in the long-term care sector;
(b) has at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting; and
(c) has demonstrated leadership and communication skills. O. Reg. 79/10, s. 213 (4).

Order / Ordre :

The licensee must be compliant with s. 213 (4) of the Ontario Regulation 79/10.

Specifically, the licensee must:

a) Ensure that everyone who is hired into the position of Director of Care has at least one year experience working as a registered nurse in the long-term care sector, and at least three years of experience working as a registered nurse in a managerial or supervisory capacity in a health care setting.

b) Develop and implement a process to ensure that the licensee, in addition to the Administrator, is involved in the recruitment process for all management positions within the home.

Grounds / Motifs :

1. The licensee has failed to ensure that everyone hired as a Director of Nursing and Personal Care had at least one year of experience working as a registered nurse in the long-term care sector.

A complaint was submitted to the Director, regarding the qualifications and past work experience of the DOC.

Upon entering the home, the Administrator advised the Inspectors that DOC #122 had resigned from their position as DOC and that the position was being covered by the Administrator until a new DOC started. Please refer to WN #8 for further details.

Inspector #690 reviewed DOC #122's resume and identified that DOC #122 did not have any previous employment experience in long-term care.

In an interview with Inspector #690, DOC #122 indicated that they had accepted the position of DOC on a specific date, and had resigned from the position in September 2019. DOC #122 indicated that, prior to their position of DOC at Belvedere Heights, they did not have any previous experience working in long-term care.

During an interview with the Administrator, they stated that DOC #122 started in the position of DOC on a specific date. The Administrator stated that they were aware that DOC #122 did not have the required qualifications when they hired them.

The severity of this issue was determined to be a level two, as there was minimal harm or minimal risk to the residents of the home. The scope of the issue was a level three, as it was identified to have the potential to impact all of the residents in the home. The home had a level two compliance history, as they had no previous non-compliance with this section of the Ontario Regulation. (681)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 19, 2019

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 4th day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Stephanie Doni

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