Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue le Loi de 2007 les foyers de soins de longue durée

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

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

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Amended Public Copy/Copie modifiée du public de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 18, 2018;	2018_703625_0001 (A2)	000668-18	Resident Quality Inspection

Licensee/Titulaire de permis

St. Joseph's Care Group
35 North Algoma Street P.O. Box 3251 THUNDER BAY ON P7B 5G7

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

Bethammi Nursing Home
63 Carrie Street THUNDER BAY ON P7A 4J2

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

Amended by STEPHANIE DONI (681) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The licensee has requested and been granted an extension to compliance order #001, 002, 003, 005, and 008.

Issued on this 18 day of May 2018 (A2)

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

Original report signed by the inspector.

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Amended by STEPHANIE DONI (681) - (A2)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): January 29, 30 and 31; February 1, 2, 5, 6 and 7, 2018.

Additional intakes completed during this inspection were:

- One follow-up to CO #001 issued during inspection #2017_463616_0007 related to security of medications;

- Five complaints related to the home's staffing complement and the provision of nursing and personal support services to residents;

- One Critical Incident System (CIS) report related to alleged staff to resident abuse;

- One CIS report related to alleged staff neglect of a resident;

- One CIS report and complaint forwarded to the Director by the home related to alleged neglect of a resident;

- Six CIS reports related to responsive behaviours and potential resident to resident abuse; and

- One CIS report related to a fall which resulted in a significant change in status of a resident.

During the course of the inspection, the inspector(s) spoke with residents, family members, a manufacturer's representative, the Infection Prevention and

Control (IPAC) Lead, Personal Support Workers (PSWs), Registered Practical Nurses (RPNs), Registered Nurses (RNs), the Environmental Services Manager (ESM), the Director of Care (DOC) and the Administrator.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents and observed staff and resident interactions. The Inspectors also reviewed relevant health care records, meeting minutes, incident reports, staffing documents, reports, and licensee policies, procedures and programs.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping

Accommodation Services - Maintenance

Continence Care and Bowel Management

Falls Prevention

Infection Prevention and Control

Medication

Minimizing of Restraining

Prevention of Abuse, Neglect and Retaliation

Residents' Council

Responsive Behaviours

Skin and Wound Care

Sufficient Staffing

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

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

s. 6. (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 written plan of care for each resident set out clear directions to staff and others who provided direct care to the resident.

Resident #027 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a Resident Assessment Instrument - Minimum Data Set (RAI-MDS) assessment.

Inspector #625 reviewed resident #027's RAI-MDS assessment dated the fall of 2017, which identified the resident had multiple areas of altered skin integrity.

A review of the PSW Treatment Administration Record (TAR) for a month in the winter of 2018 for resident #027, identified that staff were to complete a specific treatment for to an area of the resident's body with altered skin integrity, at a specified frequency.

A review of orders related to skin and wound care for resident #027 identified orders dated:
- the fall of 2017, by the wound care physician consultant #126, to complete a treatment to an area of the resident's body; and

- three dates in the fall of 2017 and winter of 2018, by the wound care nurse consultant #127, to complete three different treatments to a particular area of the resident's body.

The Inspector also reviewed the resident’s additional health care record documents and identified that the most recent order, and that listed on the current TAR, was not listed on the resident’s current care plan, Kardex or "Wound Assessment Tool". The resident’s current care plan and Kardex identified that the resident required a treatment that differed from those orders reviewed by the Inspector and instructed the staff to "...Follow other directions from [wound care physician consultant #126]”, although there was no current order for the treatment and wound care physician consultant #126's order was no longer the current order.

During an interview with PSW #106, they stated that PSWs referred to the TARs to show them what to do for residents with respect to skin and wound care.

During an interview with RPN #122, they stated that staff who processed physicians' orders were required to update the TARs. The RPN acknowledged that resident #027’s skin and wound care orders, including the current order dated the winter of 2018, had not been updated on the TARs at the time of the order.

During an interview with RN #102, they acknowledged that two most recent orders had not been included on the TAR for PSWs to refer to until a month in the winter of 2018, 44 days after the first order and 9 days after the second order. The RN acknowledged that resident #027’s plan of care did not provide clear direction to PSW staff with respect to the skin and wound care treatments in place for the resident.

During an interview, RN #103 stated that the care plan reference to a treatment which differed from the orders reviewed by the Inspector, and which also referred to following orders from the wound care physician consultant #126, were not current and should have been removed from the care plan. The RN stated that the wound care physician consultant #126 had been away from work and had been replaced by the wound care nurse consultant #127 who completed regular wound rounds in the home. The RN indicated that any reference to wound care physician consultant #126 in resident care plans should have been updated to reflect the current consultant and corresponding orders.

During an interview with the Administrator, they stated that the wound care

physician consultant #126 had been away from work for months and the PSW TARs were required to have the current wound care treatments listed to provide clear direction to PSW staff on the skin and wound care interventions they were required to provide to the resident. [s. 6. (1) (c)]

2. 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.

A complaint was received by the Director in the winter of 2018, concerning residents with responsive behaviours in the home that were required to have a particular staffing level and were not being provided with the staffing level required. The complaint indicated that resident #001 was exhibiting responsive behaviours, some of which involved other residents.

In addition, there were multiple Critical Incident System (CIS) reports received by the Director, over several months in 2017 and 2018, concerning resident #001.

A review of resident #001's health care record identified that resident #001 had multiple incidents of responsive behaviours involving other residents that were documented in the electronic progress notes, over several months in 2017 and 2018. A number of the incidents occurred between residents #001 and #002.

A review of physician orders for resident #001 identified an order for a particular level of staffing written in the fall of 2017, to assist with monitoring and minimizing resident #001's responsive behaviours.

A review of resident #001's schedule of staffing coverage for a month in 2017, identified the ordered type of staffing was not in place for 31 out of 90 shifts, or 34 per cent of the shifts; in addition, five out of 90 shifts, or 6 per cent of the shifts, did not have the ordered staffing level coverage for the entire shift. A review of the staffing level coverage for another month in 2017, identified there was no ordered staffing level coverage for 64 out of 93 shifts, or 69 per cent of the shifts; in addition, 40 out of 93 shifts, or 43 per cent of the shifts, did not have the ordered staffing level coverage for the entire shift. A review of the ordered staffing level coverage during a month in 2018, identified there was no ordered staffing level coverage for 90 out of 91 shifts, or 99 per cent of the shifts that month.

A review of the resident #001's progress notes identified that, at the time of all the responsive behaviours that occurred between residents, on multiple dates in the

fall of 2017 to the winter of 2018, the ordered staffing level coverage was not utilized.

Inspector #577 conducted interviews with the DOC and Administrator who reviewed resident #001's progress notes related to responsive behaviours and the schedule of the ordered staffing level coverage. The DOC and Administrator acknowledged that the staffing level coverage was ordered in the fall of 2017, and it was the expectation that the staffing would have always been in place, but was not provided consistently due to staffing issues. [s. 6. (7)]

3. Resident #033 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed the resident's RAI-MDS assessment dated the fall of 2017, which identified the resident had multiple areas of altered skin integrity.

A review of resident #033's health care record included:
- the TAR for a month in the winter of 2018, that indicated staff were to complete a treatment related to continence at a specified frequency, and a treatment related to the resident's altered skin at another specified frequency;
- the floor's schedule for the continence treatment that identified the resident was to have the treatment completed at the frequency specified in the TAR, and that it had been due on a particular date in the winter of 2018, but was completed nine days after that date;
- the current Kardex and care plan that identified staff were required to complete an intervention related to altered skin integrity at a specified frequency, as ordered by the physician; staff were to complete the continence treatment at the frequency specified in the TAR; and staff were to communicate the need for another treatment related to altered skin integrity to registered staff when it was required.

During an interview with resident #033, they stated that the treatment related to continence had not been completed at the frequency listed in the TAR, but less often; staff did not complete one intervention related to altered skin integrity when appropriate; and the second intervention related to altered skin integrity had not been completed on more than one occasion, resulting in a negative consequence to the resident on one of the occasions.

During an interview with RN #103, they stated that resident #033 had been scheduled to have the treatment related to continence completed on a date in the

winter of 2018, but that the RN had not completed the treatment until 9 days later. The RN stated the treatment was done late due to staffing constraints with the registered nursing staff. The RN stated they tried to complete the continence treatments within a few days of the due date and acknowledged that the continence treatment scheduled for the date in the winter of 2018, had been completed nine days late.

During an interview with the Administrator, they stated they had confirmed with the DOC that resident #033 had spoken to them about a treatment for altered skin integrity not being completed. The Administrator stated staff were expected to provide care to residents as per the plan of care which included completing the specific continence treatment when due, the intervention related to altered skin integrity when due, and the treatment related to altered skin integrity when due. [s. 6. (7)]

4. During a staff interview with Inspector #621, it was identified that resident #038 had a recent fall.

On review of resident #038's current care plan related to the fall, Inspector #621 identified that resident #038 required, as part of their falls prevention strategies, the utilization of a mobility aid with a safety device.

During an observation of resident #038 using their mobility aid, Inspector #621 found no safety device being utilized.

During interviews with PSWs #110 and #111, they reported that they had never known resident #038 to have used the safety device when using their mobility aid.

During an interview with RN #102, they reported that as part of daily staff rounds, registered and non-registered staff reviewed resident care plans to identify changes required, with registered staff responsible to update the care plans with the necessary changes. RN #102 confirmed that this resident's care plan identified that this resident used a mobility aid with a safety device, when they did not.

During an interview with the Administrator, they reported that, PSW staff were expected to review resident care plans as part of staff rounds activities, and communicate any required changes to registered staff so that required amendments to the care plan could be promptly made. [s. 6. (7)]

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

Inspector #621 observed resident #038's bed to have a safety device present.

A review of resident #038's plan of care, including their most current care plan, identified that one of the falls prevention strategies for this resident included the use of the safety device.

During interviews with PSW #111 and RN #102 they reported that PSW staff were to document completion of any treatments ordered in the TAR for each of their assigned residents, which included initialing under the corresponding date and time in the TAR that monitoring of a resident's safety device was completed at least once per shift. Both the PSW and the RN confirmed that, as part of resident #038's plan of care, the resident utilized the safety device as one of their falls prevention strategies.

During a review of resident #038's TAR for a month in the winter of 2018, both PSW #111 and RN #102 confirmed that there was no documentation that monitoring had been completed for resident #038's safety device at various times on multiple dates. Additionally, RN #102 confirmed that the provision of care as set out in the plan of care with respect to ensuring that resident #038's safety device was operational each shift, had not been documented as required. [s. 6. (9) 1.]

6. Inspector #621 observed resident #035's bed to have a safety device present.

During a review of resident #035's plan of care, including their current care plan, Inspector #621 identified that one of the falls prevention strategies for this resident included the use of a safety device.

During interviews with PSW #111 and RN #102, they reported to Inspector #621 that PSW staff were responsible for documenting completion of any treatments ordered in the TAR for each of their assigned residents, which included initialing under the corresponding date and time in the TAR, that monitoring of a resident's safety device was completed at least once per shift. Both PSW #111 and RN #102 confirmed to the Inspector that as part of resident #035's plan of care, the resident utilized a safety device as part of their falls prevention strategies.

During a review of resident #035's TAR for a month in the winter of 2018, both

PSW #111 and RN #102 confirmed that there was no documentation that monitoring had been completed for resident #035's safety device at various times on multiple dates. Additionally, RN #102 confirmed to the Inspector that provision of care as set out in the plan of care with respect to ensuring that resident #035's safety device was operational each shift, was not documented as required. [s. 6. (9) 1.]

7. Resident #029 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #029's RAI-MDS assessment dated the fall of 2017, which identified the resident had altered skin integrity.

A review of the instructions for completion of the "Wound Assessment Tool" identified that staff were to complete specific documentation on the tool with each dressing change.

A review of the resident's "Wound Assessment Tool" on a particular date in the winter of 2018, identified that the treatment for the resident's altered skin integrity was to occur at specific frequencies. The last two documented treatments were dated 13 and seven days prior, which did not reflect the treatment had been had been completed at the frequency specified on the tool.

During interviews with PSWs #106 and #123, they stated that resident #029's treatment was completed at a specified frequency due to an activity that occurred.

During an interview with RPN #124, they stated that staff were required to document on the "Wound Assessment Tool" each time resident #029's treatment was completed. The RPN stated that the treatment was to be completed at a specified frequency, and the last recorded treatment was dated a number of days earlier, which was less than the frequency specified.

During an interview with RN #102, they stated the completion of the treatment should be documented on the "Wound Assessment Tool" and that resident #029's treatment had last been documented as completed on a particular date in the winter of 2018. The RN acknowledged that, as the treatment was usually completed at a specific frequency, the staff were not documenting the provision of care set out in the plan of care with respect to resident #029's altered skin integrity. [s. 6. (9) 1.]

8. Resident #027 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #027's RAI-MDS assessment dated a particular date in the fall of 2017, which identified the resident had multiple areas of altered skin integrity.

Five days into the current month in the fall of 2018, at 1700 hours, Inspector #625 observed the PSW TARs for that month for one of the floors to be stacked in a pile at the nursing station, unsigned. The TARs contained skin and wound care interventions, as well as other interventions such as falls prevention interventions, which the PSWs were required to implement and document on when completed. The interventions listed on resident #027's current TAR, including several interventions related to altered skin integrity, did not contain documentation to identify they had been completed various times each day.

During an interview with PSW #106, they stated that the TARs listed the interventions that PSWs were required to provide to residents and PSWs were to document on the TARs when the interventions listed were completed. The PSW also stated that PSWs were required to complete a treatment related to resident #027's altered skin integrity which would need to be documented on the resident's TAR by the PSWs.

During an interview with PSW #123, they acknowledged that, although it was the evening shift five days into the current month, the TARs had not been filed in PSW assignment binders for PSWs to refer to when providing care and no treatments or interventions listed in the TARs (including the treatments for altered skin integrity) had been documented as completed for any of the residents on that floor [on which half of the home’s 112 residents resided].

During an interview with RN #102, they acknowledged that the TARs for one of the floors had not been filed in the PSW binders as of the evening shift five days into the current month, and that staff had not documented any care provided on the TARs up to that time.

Five days into the current month, at 1700 hrs, during an interview with the Administrator, they acknowledged that the current month's TAR for one of the floors had not been placed in the PSW binders for PSWs to refer to, or to

document on when care had been provided as listed, and that some interventions on the TAR had been completed but had not been signed for by the PSWs. [s. 6. (9) 1.]

9. Complaints were received by the Director related to the impact that staffing shortages had on the provision of nursing and personal care services to residents. One complainant alleged that the home had many staffing shortages and the home's staff were working with less than a full complement of staff on a daily basis.

(A) During an interview with PSW #110, they stated to Inspector #625 that the floor they worked on was short two PSWs over a weekend in January 2018, and that no documentation of the care provided that shift was completed by PSWs as a result.

(B) During several interviews with PSW #106, they stated that they had not been able to complete PSW charting on a particular date in December 2017, due to insufficient PSW staffing. They also stated that they had not been able to complete PSW documentation for multiple residents during a shift on a particular date in February 2018, and had only documented one limited item that occurred, due to insufficient staffing.

Inspector reviewed Dietary Reports for a particular date in February 2018, with a focus on meals, snacks and beverages offered during the shift identified by PSW #106, for the residents PSW #106 identified they had been required to provide care to and document on that shift. None of the residents had any documented meal, beverage or snack intervention details documented, including the amount of intake, if they were on a leave of absence (LOA), refused or were sleeping.

The Inspector also reviewed a floor's PSW Flowsheets for the specific shift on date in February 2018, for the multiple residents indicated above, and identified that 89 per cent of the residents did not have any documentation completed on the flowsheets including: bladder and bowel continence and function, oral care, cognitive pattern, mood and behaviour, special needs (glasses, hearing aids, sleep/rest), assistive devices/PASDs or pain symptoms.

(C) Inspector #625 reviewed a specific floor's Bath Schedules Home Areas #1 and #2, and identified 55 residents scheduled for baths one to two times weekly.

A review of PSW bathing flowsheet reports for January 2018, identified that, of the residents on that floor:

- 11 had one bath documented;
- 16 had two baths documented;
- 11 had three baths documented;
- four had four baths documented;
- five had five baths documented;
- one had six baths documented;
- one had seven baths documented; and
- one had eight baths documented.

The Inspector reviewed another specific floor's Bath Schedules Home Area #1 and #2, and identified 55 residents scheduled for baths one to two times weekly.

A review of PSW bathing flowsheet reports for January 2018, identified that, of the residents on that floor:
- 22 had zero documented baths;
- 28 had one bath documented;
- five had two baths documented; and
- one had three baths documented.

The review of the PSW bathing flowsheet reports for January 2018 identified that no resident had 100 per cent of their scheduled baths documented, whether provided, refused or on a LOA.

During an interview with PSW #134, they reviewed the PSW flowsheet bathing reports that identified multiple residents had baths documented only once or twice in January 2018. The PSW stated if the floor was one PSW short on those dates, the baths were "probably not charted", but if the floor was two PSWs short the baths were "probably not given".

(D) PSW #123 identified that PSW documentation was not completed on a particular shift on a date in February 2018, as one of the floors was short two PSWs leaving four PSWs to provide personal care to 56 residents. [s. 6. (9) 1.]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 001

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

WN #2: The Licensee has failed to comply with LTCHA, 2007, 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 for the home to meet the assessed needs of the residents.

(A) During a review of residents' #027, #029 and #033 health care records by Inspector #625, it was identified that resident #029 had not received a weekly wound assessment completed by a member of the registered nursing staff since a specific month in the fall of 2017, and residents #027 and #033 had not received weekly wound assessments completed by a member of the registered nursing staff

since another specific month in the fall of 2017, although all three residents had current areas of altered skin integrity.

During an interview with RN #103, they stated that staff had not been completing any form of weekly wound assessment for the residents as they did not have enough time in their shift to do so, and that staff generally did not have time to complete wound assessments, chart them, or adhere to a daily schedule for wound assessment charting.

Refer to Written Notification (WN) #4, findings #1, #2 and #3, for details.

(B) During a review of resident #033's health care record by Inspector #625, it was identified that a treatment related to continence for resident #033's was completed nine days after the scheduled date.

During an interview with RN #103, they stated that they had completed the treatment nine days late due to staffing constraints with the registered nursing staff. The RN stated that they attempted to complete the continence related treatments within a few days of the due date, in general.

Refer to WN #1, finding #3, for details.

(C) Inspector #625 had observed the practice of an RPN administering a specific medication to a resident in a specific manner in the dining room.

During interviews with RPNs #107, #118, #119 and #120, they stated that they administered the specific medication to residents in the dining rooms. Three RPNs identified that the current RPN workload assignment in the home did not provide sufficient RPN resources, when considering the time required to relocate residents already seated in the dining room to another location, to administer the medication elsewhere for the privacy of the residents.

Refer to WN #8, finding #2, for details.

(D) Inspector #625 observed an RPN fail to maintain the confidentiality of personal health information (PHI) contained in the MAR.

During interviews with RPNs #107, #118 and #119, they stated that they did not have time to close or lock each resident's eMAR when stepping away from the

medication cart due to time constraints involved with medication administration passes in the home. They identified that the current RPN staffing and workload assignment in the home did not provide the RPN the time required to close or lock the eMAR.

Refer to WN #8, finding #3, for details.

(E) Inspector #625 reviewed a staff complement document provided by Staffing Coordinator #109 that identified, when fully staffed, the home had one registered nurse on day, evening and night shifts. The document also identified that the home had one RPN assigned to administer medications per floor [56 residents per floor], on day and evening shifts; one float RPN on day and evening shifts; and one RPN on night shifts; and, as a trial up to March 31, 2018, the home had attempted to implement one additional RPN on the day shift during weekdays.

The document identified that, during the month of December 2017, there were ten day and six evening shifts where the home was short an RPN, resulting in eight shifts where two RPNs, out of three to four RPNs, or 50 to 67 per cent of the scheduled RPNs, were in the home to care for 112 residents. During one of the evening shifts where only two RPNs were in the home, there was also no RN in the home from 1500 hours (hrs) to 1900 hrs. On one night shift, there was no RPN in the home.

The document further identified that, during the month of January 2018, there were:
- 19 day shifts where the home did not have the full RPN complement working, including 14 day shifts, where one or more RPN(s) were missing for the entire 0700 to 1500 hrs shift; and
- nine evening shifts where the home did not have the full RPN complement working, including eight evening shifts where one RPN was absent for the entire 1500 to 2300 hrs shift.

An analysis of the staff complement document determined that there were 17 day and evening shifts where two RPNs worked during the shift, including 15 shifts, where two RPNs out of three to four RPNs, or 50 to 67 per cent of the RPNs scheduled, worked for the entire shift. There were six night shifts where there was no RPN in the home and one night shift where there was no RN in the home.

During an interview with float RPN #120, they stated that the float RPN did not administer medications when they were the third RPN working between the two

floors, but responded to incidents such as falls and completed some treatments, as the RPN responsible for medication administration did not have time to do those things when administering medications to 56 residents.

During an interview with RPN #122, they stated that on a particular date in January 2018, the home only had two RPNs working, and did not have a float or trail RPN working, resulting in two out of four, or 50 per cent of the scheduled RPN positions being unfilled. They identified that, with only two RPNs working that shift, they were required to deal with acute resident incidents, obtain vital signs prior to administration of certain medications, administer medications to 56 residents, participate in rocket rounds (interdisciplinary team huddles), process doctor's orders, etc.

During an interview with the home's Staffing Coordinator #109, they stated that the home struggled with staffing, including RPN staffing, due to empty rotations, sick calls and staff not picking up shifts/over time shifts.

During an interview with the home's Administrator, they stated that RPNs were required to administer medications to 56 residents, even when there was a third/float RPN as they had other assigned duties. The Administrator identified that the home had attempted to implement a trial where an additional RPN would be brought into the home during weekday day shifts to address the challenges the home was experiencing with respect to the staffing and workload challenges of the RPNs. They acknowledged the staffing deficiencies detailed in the staffing complement document and that the home was operating with significant staffing shortages and challenges. [s. 8. (1) (a)]

2. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

Complaints were received by the Director related to the provision of personal support services to residents in the home. The complaints alleged that the home did not have sufficient staffing to provide adequate personal support services to the residents in the home.

(A) Five days into the current month in the fall of 2018, at 1700 hours, Inspector #625 observed the PSW TARs for that month, for one of the floors, to be stacked in a pile at the nursing station, unsigned.

During an interview with PSW #123, they stated that staff on the night shift had not had time to file the TARs in PSW binders, and staff on day and evening shifts had not had time to sign the TARs, which is why, for five days, the sheets had not been filed and staff hadn't noticed their absence.

Refer to WN #1, finding #8, for details.

(B) During a review of Point of Care Flowsheets for January 2018, and interviews with the home's staff, it was identified by Inspector #625 that multiple baths had not been provided to residents as per their plans of care.

During interviews with the home's staff, they identified that working with less than the designated staff complement resulted in residents not receiving their scheduled baths.

Refer to WN #12, finding #1, for details.

(C) During an interview with Inspector #625, resident #012 identified that they had not been provided with oral care as per their plan of care.

During interviews with staff, they identified that the failure to provide oral care to the resident as detailed in their plan of care was related to insufficient staffing levels.

Refer to WN #20, finding #1, for details.

(D) During interviews with resident #037, they had identified that they had to wait for extended periods of time for assistance with toileting when the home was short staffed.

During interviews with the home's staff, they identified that, when they had worked with less than the designated staff complement, residents had to wait for longer periods of time for staff to respond to their call bells and provide required assistance to them.

Refer to WN #13, finding #1, for details.

(E) Inspector #625 observed residents #003 and #053 wait in excess of 20 minutes for their call bells to be answered.

A review of the Responder 4000 Reporting Software reports (logs listing the location, time and duration of call bell use) for the residents identified multiple occasions where the residents waited in excess of 19 to 75 minutes for their call bells to be responded to.

During interviews with the home's staff, they identified that working with less than the designated staff complement resulted in call bells alarming for longer periods of time as staff were not able to respond to them promptly.

Refer to WN #8, finding #1, for details.

(F) During interviews with Inspector #625, the home's staff identified that the provision of between meal beverages and snacks was not being completed. Numerous staff identified the workload, including working with less than the full PSW staffing complement, as the reason why the beverages and snacks were not offered to all residents regularly.

Inspector #625 reviewed one of the floor's Dietary Report for January 2018 and identified that there was no documentation for 48 out of 56, or 86 per cent, of the residents to indicate that they were served, refused, on a leave of absence (LOA) or sleeping with respect to the "AM snack"/morning beverage pass. The report also identified all of the residents on that floor had ten or less documented entries out of the 31 days in January, or less than 35 per cent, of their afternoon beverage and snack entries documented.

Refer to WN #7, finding #1, for details.

(G) During interviews with Inspector #625, the home's staff identified that documentation of the provision of care provided as per the plan of care did not occur. The staff attributed working with less than the full PSW staff complement as the reason why documentation of the care provided was not completed as required.

A review of various residents' health care records by the Inspector identified the failure of staff to document the care provided to residents.

Refer to WN #1, findings #7, #8 and #9, for details.

(H) Inspector #625 reviewed documents related to a written complaint and a CIS report regarding the neglect of resident #068. The documents identified that the home had experienced staffing at less than the full PSW complement at the time of the incident, and that the staffing constraints had impacted the provision of care to the resident at that time.

During an interview with the home's Administrator, they acknowledged that staffing level deficiencies had impacted the care provided to resident #068 that shift.

Refer to WN #3, finding #1, for details.

(I) Inspector #577 reviewed documents related to a complaint to the Director and multiple CIS reports concerning incidents of responsive behaviours between resident #001 and other residents. The documents identified the resident had been ordered a level of staffing in the fall of 2017, as an intervention to manage the behaviours. The documents also identified that the ordered staffing level was not provided to the resident at the time of each incident and that, in January 2018, there was no ordered staffing level coverage for 98 per cent of the shifts.

During interviews with Inspector #577, the DOC and Administrator stated that the ordered staffing level should have been in place for the resident but that it was not provided consistently due to staffing shortages.

Refer to WN #3, finding #2, for details.

(J) Inspector #625 reviewed a staff complement document provided by Staffing Coordinator #109 that identified, when fully staffed, seven PSWs worked from 0700 to 1100 hrs and six PSWs from 1100 to 1500 hrs, on each floor on the day shift. The document also identified that six PSWs worked from 1500 to 2300 hrs on the evening shift per floor, and three PSWs worked from 2300 to 0700 hrs on the night shift for the entire home.

The document detailed the home's PSW staffing deficiencies for January 2018. The Inspector noted that the home had been working with less than the full PSW staff complement on 84 per cent of the day shifts and 87 per cent of the evening shifts in January. The document further identified that one of the floors operated with less than the full PSW complement for 23 day shifts in January, or 74 per cent of the day shifts in January; and 21 evening shifts in January, or 68 per cent of the evening shifts in January. It also identified that the other floor operated with less

than the full PSW complement for 16 day shifts in January, or 52 per cent of the day shifts in January; and 20 evening shifts in January, or 65 per cent of the evening shifts in January.

During interviews with PSWs #104, #106, #108, #114, #130, #131, #134 and #135, they identified numerous deficiencies in the home's ability to provide personal support services to residents in the home. The PSWs interviewed worked throughout the home, on various shifts, and identified staffing challenges, specifically working with less than the full complement of PSW staff, as the reason for the home's inability to provide the required services.

During an interview with the home's Staffing Coordinator #109, they stated that the home struggled with staffing, including PSW staffing, due to empty rotations (temporary and permanent), sick calls, staff injuries resulting in employees requiring work modifications and staff not picking up shifts/over time shifts.

During interviews with the home's Administrator, they stated that the home could not expect the staff to do any more than basic personal care, which they struggled to get done, when staff were working short. They acknowledged the staffing deficiencies detailed in the staffing complement document, that the home was operating with significant staffing shortages and challenges and that the PSW staffing deficiencies had negatively affected resident care. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 002, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A2)The following order(s) have been amended:CO# 002,003

DR # 001 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and neglect by the licensee or staff.

Ontario Regulation 79/10, s. 5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #625 reviewed a CIS report received by the Director identifying that resident #068 was neglected on a date in the winter of 2018. The report detailed that the resident had been using a mobility aid that had become soiled with a body fluid, and that interventions the resident required related to continence had not been completed all day. Actions to prevent recurrence listed included reinforcement of one intervention and the responsibility of staff to follow the care plan, ongoing efforts to ensure a full staffing complement, including significant recruitment and retention activities, and "meted out discipline as appropriate".

A review of resident #068's care plan that was in place at the time of the incident identified that the resident experienced a medical condition, staff were to complete an intervention related to continence at specific frequencies and were to complete another related intervention as needed.

Emails dated the winter of 2018, from resident #068's family member #136 to the

home's Administrator and DOC, identified that resident #068 had not had either of the interventions related to continence completed for an extended period of time until a family member visited the home and requested it during the evening; and the resident's mobility aid was soiled with a body fluid. The emails also identified that resident #068 had not had the continence related interventions completed on a few other recent occasions which the family member spoke to the PSW staff about and were told that the resident had not had an intervention completed due to staff shortages. The second email identified that the family member had attended the home on a particular date in the winter of 2018, and found the resident using their mobility aid which "smelled very strongly of [the body fluid]". When the mobility aid was washed by the family member and later by another PSW the email indicated the "water immediately turned [colour] and smelled of [the body fluid]" and "a lot of [the body fluid] poured out". The email from family member #136 also stated "I am concerned that this issue is not really resolved from a staff role, education, awareness or understanding of what personal dignity means".

Documented interviews with PSW #110 and the home's management identified that the PSW stated resident #068 was to receive an intervention related to continence at a specific frequency, received the intervention during the morning on date in the winter of 2018, and refused one intervention without another intervention being completed in the afternoon. The notes identified that PSW #110 informed the next shift that the resident had refused one intervention that afternoon.

Documented interviews with PSW #116 and the home's management identified that the PSW was aware that the resident had not had the intervention completed that afternoon, they did not complete either of the interventions at the beginning of the shift, and they did not complete either intervention until the resident's family member requested one intervention be completed, at which time the resident was soiled. The notes also identified that the PSW acknowledged that they should have completed one intervention at the frequency specified in the resident's care plan and that "[PSW #116] received a verbal discipline for not following care plan of [completing a specific intervention related to continence at a specific frequency] as indicated".

Notes from interviews with RNs #113 and #102 and the home's management identified that RN #113 stated they had informed RN #102 of the need for resident #068's mobility aid to be washed but RN #102 did not recall being informed of this.

Documented interview notes with PSW #137 identified that the PSW found resident #068's mobility aid in an equipment washer room and it was not wet but stated "I thought it smelled...", and they were not sure if the mobility aid had been washed but they needed it so they used it.

A review of a "Resolution of Complaints" document provided to the Inspector by the home's Administrator, identified that, in the winter of 2018, neglect occurred as resident #068 did not have either of two continence related interventions completed over a 5.5 hour period; during the night following the neglect as the resident's mobility aid was not washed or was not washed properly; and on the particular date immediate discipline and guidance was provided to the individual PSW who did not implement a continence related intervention over a four hour period, until resident #068's family raised a concern. The document had a hand written notation "Encourage staff not to complain about being short".

A review of a staffing complement document provided by Staffing Coordinator #109 identified, with respect to PSW staffing on the particular day in the winter of 2018, the home was short one PSW on one floor from 0700 hrs to 1100 hrs and one PSW from 1500 hrs to 2300 hrs; and one PSW on another floor from 0700 hrs to 1100 hrs and two PSWs from 1500 hrs to 2300 hrs. The document indicated that the home was short a total of 3 PSWs [out of 12] on the shift when the incident occurred.

A review of the home's resident census list identified that resident #068 resided on a particular floor, which had worked with less than the full PSW staff complement from 0700 to 1100 hrs and 1500 to 2300 hrs on the date of the incident.

During an interview with family member #136, they confirmed the details provided in the email they had sent to the home's management in the winter of 2018. The family member further stated that, with respect to the incident that occurred in the winter of 2018, the resident's mobility aid had been soiled with a body fluid and it looked like the resident had not had a continence related intervention completed all day. The family member stated that, the day after the incident, the mobility aid had not been washed, reeked of the body fluid and was still damp. The family member also identified that, on the date of the incident they had stated to a PSW "It looks like neglect" and on the next day, they repeatedly used the word "neglect" when speaking to the home's Administrator and DOC. The family member identified that the PSW involved in the incident had informed the family member that they were "short staffed" at the time of the incident and that it was evident to the family

member when the home was short staffed.

The Inspector viewed a video provided by family member #136, of the resident's moblity at the time of the incident. The video showed puddles of liquid on a portion of the mobility aid. The video identified the liquid underneath the seat cushion as a specific body fluid and that another part of the mobility aid was also saturated with the body fluid.

During an interview with the home’s Administrator, they acknowledged that resident #068 probably last had a continence related intervention completed before lunch, but that staff should have completed the continence related intervention if the resident had refused another continence related intervention earlier in the day, that the home did not have a full PSW staff complement on the date of the neglect, that the PSW involved stated that they couldn’t possibly get it all done, and that they were sure staffing affected the care provided to the resident that shift. The Administrator also acknowledged that they could not guarantee that the resident’s mobility aid had been washed after the incident, but it was washed the next day when the home suspected it had not been washed due to communication problems. [s. 19. (1)]

2. A complaint was received by the Director in the winter of 2018, concerning residents with responsive behaviours in the home that were required to have a particular staffing level and were not being provided with the staffing required. The complaint indicated that resident #001 was exhibiting responsive behaviours, some of which involved other residents.

Ontario Regulation 79/10, s. 2 (1), includes in the definition of physical abuse "the use of physical force by a resident that causes physical injury to another resident".

Inspector #577 reviewed multiple CIS reports submitted to the Director over several months in 2017 and 2018. The reports detailed abuse between resident #001 and several other residents. A report dated the fall of 2017, identified that ordered staffing levels were provided when staff were available.

A review of physician orders for resident #001 identified an order for a level of staffing written in the fall of 2017, to assist with monitoring and minimizing resident #001's responsive behaviours.

During a review of resident #001's schedule of the ordered level of staffing

coverage, Inspector #577 identified a lack of the staffing coverage provided during 34 per cent of the shifts in one month in 2017; 69 per cent of the shifts in another month in 2017; and 99 per cent of the shifts in a month in 2018.

A review of resident #001's health care record identified that resident #001 had multiple incidents of responsive behaviours towards other residents that were documented in the electronic progress notes, over a several months in 2017 and 2018 . At the time of the responsive behaviours that occurred between residents on multiple dates in the fall of 2017 to the winter of 2018, the ordered staffing coverage was not utilized.

A review of resident #001's care plan effective at the time of the responsive behaviours from the fall of 2017 to the winter of 2018, identified that staff were to utilize specific interventions to address several responsive behaviours. The care plan indicated that staff were to follow the suggestion from Behavioural Supports Ontario (BSO) and listed one specific intervention.

Inspector #577 found a list of recommended strategies documented by BSO in a Kardex binder, which included triggers, behaviours and strategies that were developed in the fall of 2017. Inspector #577 noted that these were not listed in the resident's care plan. The document identified specific responsive behaviours, specific triggers, and recommended many strategies that were not in the resident's care plan.

During an interview with PSW #116, they reported that resident #001 had exhibited responsive behaviours towards others. They reported that resident #001 would exhibit a specific behaviour and identified two specific triggers.

During an interview with PSW #117, they reported that resident #001 had exhibited responsive behaviours towards others, and identified a specific trigger. They reported that the resident exhibited a specific behaviour and an intervention the staff implemented to address the behaviour.

During an interview with PSW #138 from the BSO Mobile Outreach Team, they reported that resident #001 exhibited responsive behaviours towards others and identified several behaviours, including some that were harmful to others. They further reported that the identified triggers, behaviours and strategies should have been incorporated and written into the resident's care plan.

During an interview with RN #103 they reported that the recommended strategies, including the identified triggers, provided by BSO Psychogeriatric Resource Consultant should have been transcribed into resident #001's care plan.

Inspector #577 conducted interviews with the DOC and Administrator who reviewed resident #001's progress notes related to responsive behaviours and the schedule of the ordered staffing level. The DOC and Administrator acknowledged that the ordered staffing level was ordered in the fall of 2017, and it was the expectation that the supervision would have always been in place, but was not provided consistently due to staffing issues.They further confirmed that the triggers, behaviours and strategies documented by BSO and the nursing intervention of the ordered staffing level were not incorporated into resident #001's care plan. In addition, they confirmed that the ordered staffing level was not provided on multiple dates in the fall of 2017 and winter of 2018, when resident #001 exhibited responsive behaviours towards other residents.

Refer to WN #1, finding #2, and WN #6, finding #1 for details. [s. 19. (1)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 004

WN #4: 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 the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Resident #029 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #029's RAI-MDS assessment dated in the fall of 2017, which identified that the resident had altered skin integrity.

During an interview with resident #029, they stated to the Inspector that they currently had altered skin integrity.

The Inspector reviewed the home's program "Skin and Wound Care Program Long-Term Care" dated July 2016. The program identified that staff were to complete the Wound Tracker documentation after a dressing change and weekly documentation was to include the size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition and equipment being used. Appendix A: Skin and Wound Care – Overview identified that, with

pressure ulcers, weekly assessment and evaluation (with documentation in the resident chart, RAI, care plan) were required.

Inspector reviewed the document titled, "Wound Documentation Days" that indicated staff were required to document any wounds that the residents had on the days specified in the Wound Tracker and the documentation was to include the wound type, measurements and current treatment.

Inspector reviewed the document titled, "Wound Tracker" that identified all wounds, including pressure ulcers, were to be documented and monitored in the "Wound Tracker".

A review of the resident’s current health care record included:
- a "Wound Assessment Tool", that identified that a treatment to a particular part of the resident's body was to be completed at specific frequencies. The tool listed wound characteristics staff were to document at specified frequencies. Of the multiple documented treatments between two dates, 16 days apart, in the winter of 2018, none of the entries contained all of the required information to be recorded with each treatment and none contained the majority of characteristics required to be assessed and documented weekly. The last two documented treatments were dated seven days apart, in the winter of 2018, which did not indicate the treatment had been completed at the frequency specified on the tool. The last date the tool listed a complete assessment, including the size and characteristics of the altered skin integrity details was on a date in the fall of 2017; and
- the resident’s electronic progress notes, that identified the most recent progress note related to the altered skin integrity was dated the fall of 2017, but it did not contain an assessment of the altered skin integrity.

During interviews with RAI Coordinator #122, they stated that the home had used the "Wound Tracker" electronic assessment tool at one time as listed in the home’s Skin and Wound Care Program but had stopped using it and adopted electronic charting of wound assessments in progress notes by registered staff. The RAI Coordinator confirmed resident #029's most recent complete "weekly" wound assessment recorded on the Wound Assessment Tool was dated in the fall of 2017, approximately four months earlier, and the most recent “weekly” wound assessment completed in the Wound Tracker was dated in the fall of 2017, approximately three months earlier. The RAI Coordinator acknowledged that there was no documentation in the resident’s electronic progress notes on the altered skin integrity since a third date in the fall of 2017, approximately three months

earlier, and the last documentation on the "Wound Assessment Tool" to indicate the treatment had been completed was dated in the winter of 2018, or six days earlier.

During an interview with Inspector #625, RN #103 stated that staff were supposed to complete wound assessments in the "Wound Tracker" but had not been doing so, and had not been completing electronic progress notes for wound assessments, as they did not have enough time in the shift to do so. The RN stated that staff generally did not have time to complete wound assessments, chart them, or adhere to a daily schedule for wound assessment charting. [s. 50. (2) (b) (iv)]

2. Resident #027 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #027’s RAI-MDS assessment dated in the fall of 2017, which identified that the resident had multiple areas of altered skin integrity.

A review of the resident’s current health care record included:
- a "Wound Assessment Tool", that identified that the resident required a treatment to a part of their body to be completed at a specific frequency. The document did not list the resident’s most recent treatment order. The tool listed wound characteristics staff were to document at specified frequencies. Of the multiple documented entries listed between 12 days in the winter of 2018, none contained the majority of characteristics required to be assessed and documented weekly. The last documented entry was dated in the winter of 2018, 16 days prior.
- a review of the resident’s electronic progress notes identified the most recent progress note related to the altered skin integrity was dated in the fall of 2017. The note did not contain an assessment of the altered skin integrity.

During an interview with RAI Coordinator #122, they acknowledged that resident #027's most recent "weekly" wound assessment had been completed some time in the fall of 2017, approximately two to three months earlier. [s. 50. (2) (b) (iv)]

3. Resident #033 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #033's RAI-MDS assessment dated in the fall of 2017, which identified that the resident had multiple areas of altered skin integrity.

A review of the resident's current health care record included:
- resident #033's current "Wound Assessment Tool" which identified wound characteristics staff were required to assess and document on the tool, with each treatment and weekly. The tool indicated resident #033's treatment was to be completed at specific frequencies, and contained multiple entries in the winter of 2018. Neither of the entries contained any characteristics required to be assessed and documented with each treatment or weekly, as specified on the tool; and
- the resident's electronic progress notes which identified the most recent progress note related to the altered skin integrity was dated in the fall of 2017. The note did not contain an assessment of the altered skin integrity.

During interviews with RAI Coordinator #122, they acknowledged that #033's most recent "weekly" wound assessment had been completed in the fall of 2017, approximately three months earlier. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 005

WN #5: 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 that was secured and locked.

Compliance order #001 was issued from inspection #2017_463616_0007 pursuant to r. 129 (1) (a) (ii). The licensee was ordered to ensure that drugs were stored in an area or a medication cart that was secure and locked. The compliance due date was August 16, 2017.

On two dates in the winter of 2018, Inspector #625 observed a medicated topical treatment cream in resident #010's room. On the second date the treatment cream was observed, the resident was not in their room and no staff were present when the cream was observed.

On a date in the winter of 2018, from 0900 hrs to 0955 hrs, Inspector #625 toured the home and observed medicated topical treatments that were located in unlocked care cart lock boxes, in an unlocked treatment cart, or sitting directly on care carts. Inspector #625 observed medicated topical treatments not secured and locked, while not in use or supervised by staff.

On one floor, in four unlocked care cart lock boxes, topical treatment gels, creams, pastes and/or shampoos were observed for residents #027, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048, #049 and #050.

On another floor, in one treatment cart and in three unlocked care cart lock boxes, topical treatment gels, creams, pastes and/or shampoos were observed for residents #001, #005, #008, #051, #013, #036, #037, #035, #052, #053, #054 and #056.

During an interview with Inspector #625, PSW #104 acknowledged that they had not locked the lock box on their care cart while it was unattended and that medicated topical treatments were in the unlocked box. The PSW stated that the box should have been locked.

During an interview with PSW #105 they acknowledged that they had not locked the lock box on their care cart while it was unattended and that medicated topical treatments were in the unlocked box. The PSW stated that the box should have been locked.

During an interview with PSW #106 they stated to the Inspector that they had not locked their care cart lock box as the lock was broken and the key could not be removed when the lock was in the locked position. The PSW demonstrated this to the Inspector and stated that they were aware that the box containing topical medicated treatments should be locked.

During an interview with RN #102, they acknowledged that the treatment cart on one of the floors was not locked and contained medicated topical treatments for residents. The RN stated that registered nursing staff should lock the treatment cart when it was not in use.

During an interview with the DOC, they acknowledged that two unsupervised care cart lock boxes on one of the floors were not locked but should have been as they contained medicated topical treatments. The DOC stated that they were aware of a lock box which required repair and could not be locked at that time. The DOC also acknowledged that the treatment cart on one of the floors contained medicated topical treatments and should have been locked. The DOC and Inspector observed the unsupervised treatment cart to have the key in the lock which was used to open the cart and access the medicated treatment creams inside. The DOC then attended resident #010's room with the Inspector and acknowledged unlocked and unsecured medicated topical treatment cream present.

During an interview with the Administrator, they stated to Inspector #625 that

medicated topical treatments should be locked in care cart lock boxes when not in use and that staff were aware of this requirement. The Administrator acknowledged that a lock box currently in use in the home required repair and could not be locked until it was repaired or replaced. [s. 129. (1) (a) (ii)]

2. The licensee has failed to ensure that controlled substances were stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

Inspector #625 observed injectable Ativan 4 milligrams (mg) / milliliters (ml) stored in the second and third floor medication rooms without any lock in place except for the lock on the medication rooms' doors.

During an interview with RPN #118, they acknowledged that Ativan vials were stored in the second floor medication room fridge for multiple residents and for the night box supply, but the Ativan was not double-locked and was locked only by the door to the medication room.

During an interview with RPN #119, they acknowledged that Ativan vials were stored in the second floor medication room fridge, but that they were not double-locked.

During an interview with RPN #107, they acknowledged that two Ativan vials were stored in the third floor medication room fridge without a double-lock in place.

During an interview with RPN #120, they stated that Ativan vials were stored in the second and third floor medication rooms, but that they were not double-locked.

During an interview with the DOC, they stated to Inspector #625 that the injectable Ativan vials in the medication rooms should have been double-locked. [s. 129. (1) (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 006

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Inspector #577 reviewed CIS reports submitted to the Director on dates:
- in the fall of 2017, which identified abuse between residents #001 and #002. The report indicated that resident #001 exhibited responsive behaviours involving resident #002. As per the report, resident #002 sustained an injury. The report further indicated that several days prior, resident #001 exhibited a responsive behaviour involving resident #002, where resident #002 sustained an injury.

- in the fall of 2017, which identified abuse between residents #001 and #003. The report indicated that resident #001 exhibited a responsive behaviour involving resident #003. As per the report, resident #003 sustained an injury.

- in the fall of 2017, which identified an altercation between residents #001 and #002.

- in the fall of 2017, which identified resident #001 exhibited responsive behaviours involving resident #004. The report further indicated that resident #004 exhibited a behaviour involving resident #001, resulting in resident #004 sustaining injuries.

- in the fall of 2017, which identified an altercation between residents #001 and #005. The report indicated that resident #001 exhibited a responsive behaviour involving resident #005, which escalated into an altercation, where resident #005 then exhibited behaviours involving resident #001.

- in the winter of 2018, which identified an altercation between residents #001 and #002. The report indicated that residents #001 and #002 exhibited responsive behaviours involving each other.

A review of resident #001's health care record identified that the resident had multiple incidents of responsive behaviours towards other residents, which were documented in the electronic progress notes over several months in the fall of 2017 to the winter of 2018. The progress notes indicated the incidents occurred on multiple dates in the fall of 2017 and the winter of 2018, and the notes related to the CIS reports were consistent with the information in the reports.

A review of resident #001's care plan effective at the time of the responsive behaviours from the fall of 2017 to the winter of 2018, identified under the nursing focus Behaviours, staff were to utilize multiple interventions. The care plan intervention indicated that staff were to follow a suggestion from Behavioural Supports Ontario (BSO).

Inspector #577 found a list of recommended strategies documented by BSO in a Kardex binder, which included triggers, behaviours and strategies that were developed in the fall of 2017. Inspector #577 noted that these were not listed in the resident's care plan. The recommendations identified specific behaviours exhibited towards others and listed triggers for the behaviours. There were many recommended strategies listed that were not listed in the resident's care plan.

A review of the physician's orders for resident #001 indicated an ordered level of staffing written in the fall of 2017, the same date the oldest CIS report reviewed was dated, to assist with monitoring and minimizing resident #001's responsive

behaviours.

A review of resident #001's schedule of the ordered staffing level coverage for a month in 2017, identified there was no ordered staffing level coverage for 31 out of 90 shifts, or 34 per cent of the shifts; in addition, five out of 90 shifts, or 6 per cent, did not have the ordered staffing level coverage for the entire shift. A review of the ordered staffing level coverage for another month in 2017, identified there was no ordered staffing level coverage for 64 out of 93 shifts, or 69 per cent of the shifts; in addition, 40 out of 93 shifts or, 43 per cent of the shifts, did not have the ordered staffing level coverage for the entire shift. A review of staffing level coverage for a month in 2018 identified there was no ordered staffing level coverage for 90 out of 91 shifts, or 99 per cent of the shifts.

A further record review of the progress notes indicated that at the time of all of the responsive behaviours between residents on multiple dates in the fall of 2017 to the winter of 2018, the ordered staffing level was not utilized.

During an interview with PSW #116, they reported that resident #001 had exhibited responsive behaviours towards others. They reported a specific behaviour and trigger.

During an interview with PSW #117, they reported that resident #001 had exhibited responsive behaviours towards others, and identified a trigger. They reported specific activities resident #001 engaged in related to safety.

During an interview with PSW #138 from the BSO Mobile Outreach Team, they reported that resident #001 exhibited responsive behaviours towards others and identified multiple behaviours the resident exhibited. They further reported that the identified triggers, behaviours and strategies should have been incorporated and written into the resident's care plan.

During an interview with RN #103 they reported that the recommended strategies, including the identified triggers, provided by BSO Psychogeriatric Resource Consultant should have been transcribed into resident #001's care plan.

Inspector #577 conducted interviews with the DOC and Administrator, who reviewed resident #001's progress notes related to responsive behaviours and the schedule of the ordered staffing level. They reported that the staffing level was ordered in the fall of 2017, and it was the expectation that the supervision would

have always been in place but was not provided consistently due to staffing issues. They further confirmed that the triggers, behaviours and strategies documented by BSO and the nursing intervention of the ordered staffing level were not incorporated into resident #001's care plan. In addition, they confirmed that the ordered staffing level was not provided on multiple dates in the fall of 2017 to the winter of 2018, when there were altercations between resident #001 and other residents. [s. 54. (b)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 007

WN #7: 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).
(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).
(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 a between meal beverage in the morning and afternoon and a beverage in the evening after dinner, and a snack in the afternoon and evening.

Complaints were received by the Director related to the impact that staffing

shortages had on the provision of nursing and personal care services to residents.

During interviews with Inspector #625, PSWs #104, #106, #108, #114, #130, #131, #134 and #135 stated that beverages and snacks were not given out to residents when the staff were working short. The PSWs interviewed worked on both the second and third floors.

During an interview with PSW #105, they stated that beverages were never given to residents in the mornings, in between breakfast and lunch. The also stated that in the evenings, "99 per cent" of the time, the beverages and snacks were not given out but they would try to provide beverages and snacks to diabetic residents.

During an interview with PSW #135, they stated that when they were working short they did not give out snacks, but certain people, such as diabetic residents and those who requested a beverage or snack, were given beverages and snacks in between meals. The PSW stated that, on a date in the winter of 2018, morning beverages were not provided and that they had not observed the beverage cart go around in a long time. The PSW also stated that beverages and snacks were not offered to residents during the afternoon of the previously mentioned date in the winter of 2018, due to a staff shortage.

PSW #123 identified to the Inspector that, on the evening of a date in the winter of 2018, one floor was only able to offer beverages and snacks to diabetic residents and those residents who specifically requested them, as the floor was working with four PSWs, instead of the required complement of six.

During interviews with Inspector #625, resident #037 stated that, generally, beverages and snacks were not offered to them in the afternoons and evenings; and resident #010 stated staff did not go around to offer beverages, they were never offered a snack but they could go and ask if they wanted something.

During an interview with Inspector #621, resident #033 stated that staff did not offer beverages to residents in between meals, and they hadn’t been offered a snack in the afternoon or evening for the last seven days.

Inspector #625 reviewed the Dietary Report for a month in the winter of 2018 for one of the floors in the home, with respect to the "AM snack"/morning beverage pass, and identified that there was no documentation for 48 out of 56, or 86 per cent, of the residents to indicate that they were served, refused, on a leave of

absence (LOA) or sleeping with respect to the morning beverage pass. Of the eight residents who had documentation related to the provision of the morning beverage, all eight had only one entry in that month, including the documentation of refusals and LOAs.

The Inspector reviewed the previously mentioned Dietary Report, with respect to the "PM snack" which included afternoon beverages and snacks for 56 residents, and identified that:
- three residents had no documentation to indicate they were served, refused, on a LOA or sleeping on any date during that month;
- 14 had one documented entry;
- 14 had two documented entries;
- eight had three documented entries;
- seven had four documented entries;
- three had five documented entries; and
- seven had six to ten documented entries.

In total, 100 per cent of residents on that floor had ten or less documented entries out of the entire month in 2018, or less than 35 per cent, of their afternoon beverage or snack entries documented.

During an interview with RPN #122, they reviewed the Dietary Reports previously reviewed by the Inspector, and stated that resident #030 did not have "AM snack" listed which meant they were never recorded as being given or refusing a beverage in between breakfast and lunch; resident #060 had only one item listed for "AM snack" which meant they were never recorded as ingesting more than one morning beverage that month; resident #027 did not have "AM snack" or "PM snack" listed which meant they were never recorded as being given or refusing a morning or afternoon beverage or snack that month.

During a phone interview with RN #102, they reviewed the Dietary Reports for a specific floor during a month in the winter of 2018 and acknowledged that only eight residents had any documentation pertaining to the provision of the "AM snack"/morning beverage. [s. 71. (3)]

Additional Required Actions:

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

(A2)The following order(s) have been amended:CO# 008

WN #8: The Licensee has failed to comply with LTCHA, 2007, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The license has failed to ensure that the rights of residents were fully respected and promoted, including the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.

On a date in the winter of 2018, Inspector observed residents #003 and #053's call bells to be ringing in excess of 20 minutes.

During an interview with RN #102, they stated that all staff were required to respond to call bells. The RN attended resident #003's room with the Inspector where the resident was lying in bed. The resident stated they were not feeling well and the RN provided reassurance to the resident. The RN next attended resident #053's room with the Inspector where the resident was lying in bed. The resident communicated that they had spilled a beverage on the bed. The RN acknowledged a spilled mug and liquid on the resident's bed sheets and stated they would notify staff to come and assist the resident.

(A) A review of resident #003's current care plan identified that the resident displayed responsive behaviours and staff were to interact with the resident in a specific manner.

Inspector reviewed the Responder 4000 Reporting Software report for resident #003's call bell and identified that the resident's call bell had been unanswered in excess of 62 minutes before the Inspector and RN #102 had responded to it.

The Inspector further reviewed the Responder 4000 Reporting Software report for resident #003's call bell over seven days in the winter of 2018, and identified:
- on the first day call bell response times were in excess of 27, 32 and 37 minutes;
- on the second day call bell response times were in excess of 19, 21, 27 and 28 minutes;
- on the third day call bell response times were in excess of 46 and 75 minutes;
- on the fourth day call bell response times were in excess of 20, 43 and 62 minutes;
- on the fifth day call bell response times were in excess of 39, 49 and 71 minutes;
- on the sixth day call bell response times were in excess of 20, 24, 42 and 54 minutes; and
- on the seventh day call bell response times were in excess of 23, 25, 39 and 60 minutes;

(B) Inspector reviewed the "Responder 4000 Reporting Software" report for resident #053's call bell and identified that the resident's call bell had been unanswered in excess of 41 minutes before RN #102 had responded to it, in the presence of the Inspector.

The Inspector also reviewed the Responder 4000 Reporting Software report for resident #053's call bell over five days in the winter of 2018, and identified:

- on the third day a call bell response time was in excess of 20 minutes;
- on the fourth day a call bell response time was in excess of 41 minutes; and
- on the fifth day a call bell response time was in excess of 18 minutes.
The average call bell response time in the report period was in excess of 26 minutes.

During an interview with the Administrator, they stated that it was not appropriate for resident #003 to wait for over an hour for staff to respond to their call bell. The Administrator stated that the resident exhibited responsive behaviours and that waiting for the 20 minutes observed by the Inspector was too long for staff not to respond to the call bell. The Administrator also stated that it was not appropriate for resident #053 to wait for over 40 minutes for staff assistance when they had spilled a beverage in bed. The Administrator further stated that overall, in general, the home was not meeting the residents' care needs with poor response times to call bell calls for assistance. [s. 3. (1) 4.]

2. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to be afforded privacy in treatment and in caring for his or her personal needs.

Inspector #625 reviewed the home's pharmacy provider's policy titled "Medication Administration – Specific Administration" last reviewed in January 2017. Within section 6.14 - Insulin Administration, the policy indicated that staff were to "provide for resident privacy".

On a date in the winter of 2018, Inspector #625 observed RPN #107 administer a specific medication to resident #023. The manner in which the medication was administered by the RPN infringed upon the resident's privacy. At the time of the medication administration, the resident was seated in the dining room during a meal and other residents were present, including two residents seated at the same table as resident #023.

During an interview with RPN #107, they acknowledged that they had administered a specific medication to resident #023 in a specific manner, while in the dining room. The RPN stated that staff administered the medication to residents in the dining as they were required to administer medications to 56 residents and did not have time to administer the medication elsewhere if the resident was already in the dining room.

During an interview with RPN #118, they stated that they administered a specific medication to residents in a specific manner, while in the dining room.

During an interview with RPN #119, they stated that they did administer some specific medication in the dining rooms due to time limitations during medication passes.

During an interview with RPN #120, they stated that they did administer a specific medication, in a specific manner, in the dining room, due to time limitations. The RPN identified that they did not have time to bring the residents out of the dining room to administer the medication elsewhere.

During interview with the DOC, they stated that they were aware that staff were administering a specific medication to residents in the dining rooms in the home and that the practice should not be done as the administration of the medication should be done in private. [s. 3. (1) 8.]

3. The licensee has failed to ensure that the rights of residents were fully respected and promoted, including the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

On a date in the winter of 2018, Inspector #625 observed RPN # 107 leave resident #023's eMAR open, visible and unsupervised in the hallway outside of the resident's room while the RPN entered the room and completed an activity with the resident. The Inspector observed the resident's name, room number and specific directions for the activity the RPN completed. The Inspector again observed the RPN leave the eMAR open, visible and unsupervised in the hallway outside of the resident's room when the RPN administered a medication to the resident in their room, leaving information about the resident's medication directions visible.

Inspector #625 reviewed the home's pharmacy service providers' policy "Medication Administration – Specific Administration" last reviewed January 2017. Section 6.14 titled Insulin Administration identified that staff were to "maintain confidentiality of Medication Administration Record (MAR)".

During an interview with RPN #107, they stated to the Inspector that they did not have time to lock the eMAR when responsible for administering medications to 56 residents.

During an interview with RPN #118, they stated to the Inspector that they did not always close residents' eMARs so that personal health information (PHI) was not visible as they did not have time to do so in between medication administration to each resident.

During an interview with RPN #119, they stated that they were not usually able to close or lock residents'' eMARs so that PHI was not visible as to do so took time and, during a medication pass for 56 residents, there wasn't the time to do that when stepping away from the cart.

During an interview with the DOC, they stated to the Inspector that, to maintain the confidentiality of PHI contained in residents' eMARs, the screen should be locked when staff stepped away from the eMAR to provide medications to residents. [s. 3. (1) 11. iv.]

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 that ensures that the rights of residents are fully respected and promoted, including:
- the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs; and
- the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #9: 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 Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, that the plan, policy, protocol, procedure, strategy or system, was complied with.

Ontario Regulation 79/10, s. 53. (1) 1 and 2 require the licensee to ensure that written approaches to care, including screening protocols, and written strategies, were developed to meet the needs of residents with responsive behaviours.

Multiple CIS reports were received by the Director over several months the fall of 2017, to the winter of 2018, related to responsive behaviours that occurred between residents #001, #002, #003, #004 and #005. The reports indicated that resident #001 was involved in all of the interactions.

Inspector #577 reviewed resident #001's progress notes and found multiple incidents of responsive behaviours involving other residents that were documented over several months between the fall of 2017, and the winter of 2018.

A review of the home's "Responsive Behaviours Toolkit" last revised May 2016, indicated that it was the responsibility of the staff assigned to a particular staffing level to document, by entering a note on the residents' health record, a summary of the resident's response to the staffing level monitoring and response to the strategies and interventions utilized.

A review of resident #001's physician orders indicated that a particular staffing level was ordered in the fall of 2017, to assist with monitoring and minimizing

resident #001's responsive behaviours.

During a review of resident #001's progress notes for documentation of their response to the ordered staffing level, Inspector #577 found there was no documentation of the resident's response for 29 out of 33 of the shifts, or 88 per cent of the shifts, in one month in the fall of 2017. In addition, the following month, there was only one progress note pertaining to the ordered staffing level's required documentation.

During an interview with PSW #139 they reported that the staff member assigned to the staffing level monitoring was responsible to document a progress note at the end of their shift that summarized the strategies used and the resident's behaviour.

During an interview with RN #103 they reported that the PSW assigned the the staffing level monitoring was responsible to document a progress note that summarized the residents' behaviour throughout the shift.

Inspector #577 interviewed the DOC who had reviewed the Responsive Behaviours Toolkit, which indicated that the staff member assigned to the staffing level monitoring was responsible to enter a note that summarized the resident's response to the staffing level. The DOC confirmed that the practice was not consistently done, and the responsive behaviours toolkit was not being followed. [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 that ensure that, where the Act or 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, that the plan, policy, protocol, procedure, strategy or system is complied with, specifically with respect to responsive behaviours strategies, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with LTCHA, 2007, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, without in any way restricting the generality of the duty provided for in section 19, there was in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy was complied with.

Inspector #621 reviewed a CIS report submitted by the home to the Director regarding an incident of alleged neglect of resident #007 by PSW #114. The alleged neglect occurred in the fall of 2017, however, the home did not report the incident to the Director until one day after it had occurred.

The home's policy titled "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications About Incidents of Abuse or Neglect – LTC 5-51", last revised February 2016, indicated that the Director/designate and/or VP Seniors' Health was to be notified immediately and they would then notify the Ministry by phone and immediately initiate a report using the online mandatory Critical Incident System.

A review of the home's investigation identified that, during a shift in the winter of 2017, PSW #115 reported to RN #113 that PSW #114 had neglected resident #007, leaving the resident requiring assistance, as they went on a break. Additionally, email communication to the DOC on the same date, from PSWs #115 and #112, identified that they both reported to RN #113 that resident #007 had been left by PSW #114 requiring assistance.

During an interview with RN #113, they reported to Inspector #621 that, if they suspected abuse or neglect of a resident, they would notify the leadership on-call if it was after regular business hours, and obtain direction on calling the MOHLTC from them. RN #113 also reported that they would notify the DOC and/or Administrator of the incident by email. With regards to the incident where PSWs #115 and #112 alleged neglect of resident #007 by PSW #114, RN #113 reported to the Inspector that they had assessed the situation and felt that neglect had not occurred. As a result, RN #113 confirmed that they had not contacted the licensee's leadership that was on-call at the time of the incident, and instead waited until the following day, in the mid-afternoon, to notify the DOC by email.

During an interview with the DOC, they reported to Inspector #621 that they had become aware of the alleged incident of neglect on their return to work on the morning of the date following the incident, when they reviewed their email from PSWs #115 and #112 sent on the date of the incident. The DOC reported that they had not been the manager/designate on-call on the date of the incident, and consequently did not see the emails until their return to work the next business day.

During an interview with the Administrator, they reported that registered staff were expected to follow the home's policy for reporting incidents of alleged or suspected neglect, and contact the manager on-call and/or VP Senior's Health when it was after business hours, so that MOHLTC could be notified immediately. The Administrator acknowledged that, RN #113 should have treated the reports made by PSWs #115 and #112 on the date of the incident, as an incident of alleged neglect, and followed the home's policy for reporting, but had not. [s. 20. (1)]

2. A CIS report was received by the Director on a date in the winter of 2018. The report identified that resident #068 was neglected on the previous date, greater than 22 hours earlier, that PSW #116 was present and RN #113 discovered the neglect of resident #068.

A review of the home's policy "Zero Tolerance of Abuse and Neglect of Residents Reporting and Notifications Abuse Incidents of Abuse or Neglect" approved February 2016, identified that:
- Any employee who was aware of or suspected any of the following was required to report it as soon as possible in accordance with reporting procedures of the home: improper or incompetent treatment of care of a resident; abuse of a resident by anyone or neglect of a resident by an employee; verbal complaints concerning resident care or operation of the home.
- Employees who had witnessed or suspected an alleged incident of resident abuse or neglect were required to immediately report to the Director/designate or VP Seniors' Health.
- The Director/designate receiving the report of alleged witnessed or unwitnessed abuse or neglect was required to notify the VP Seniors' Health or designate (or, if after hours, senior administration on call) and the Director, MOHLTC immediately.
- The VP Seniors' Health/Senior Administration on call was responsible to ensure all appropriate steps had been taken by the appropriate parties according to the policy and procedures regarding Zero Tolerance of Abuse and Neglect; determine the appropriate management action(s) to be taken as a result of the findings of investigation (e.g. education, discipline, policy revision, mandatory reporting to relevant professional college).

During a phone interview with Inspector #625, family member #136 stated that, at the time they were viewing the resident's mobility aid, a PSW walked by and the family member stated that "it looks like neglect" to them. They stated that they ensured the RN on duty viewed the mobility aid saturated with a body fluid when the family member informed them of the incident.

A review of an email sent on the date of the incident in the winter of 2018, from family member #136 to the Administrator, identified that they had learned resident #068 had not had two continence related interventions completed until the evening that day, the mobility aid used by the resident all day was soaked and dripping a body fluid, and this was reported to the RN on duty at the time.

A review of an email dated the date of the incident, from RN #113 to the Administrator and DOC, identified that the RN was reporting a concern from resident #068's family, that the resident had not had a continence related intervention completed during the previous shift and prior to a meal and that the resident's mobility aid was drenched with a body fluid.

During a phone interview with the Administrator, they stated that, as per the home's zero tolerance of abuse and neglect policy, staff were required to report neglect of a resident by the licensee or staff to the home's management or designate. The Administrator identified that, when no management was in the home, the RN was the designate to whom neglect was reported, who would be required to fulfill reporting requirements. The RN would have been responsible to call leadership on call and would have been given direction to call the MOHLTC. The Administrator acknowledged that it would have been clear that improper care had been provided [which the abuse policy addresses] if the resident was found using a mobility aid saturated with a body fluid to the extent described, and the RN had visually seen the mobility aid. They stated that it was reasonable to suspect that improper care had occurred and the PSW should have notified the RN who should have notified the leadership team who would have given the direction to report the incident to the MOHLTC. [s. 20. (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 that ensures that, without in any way restricting the generality of the duty provided for in section 19, there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and that the policy is complied with, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

The Long-Term Care Homes Act, 2007, s. 11. (1) requires the licensee to have organized programs of nutrition care and dietary services and hydration to meet the needs of residents. As part of the nutrition care and hydration programs, Ontario Regulation 79/10, s. 68 (1) (e) (i) requires the home to have a weight monitoring system to measure and record monthly weights, with respect to each resident.

Inspectors #621 and #625 reviewed MED e-care electronic monthly weight records and identified missing monthly weights for residents #001, #026, #027, #028, #029, #030, #031, #032 and #033.

During interviews with PSWs #123 and #140, they reported to Inspector #621 that resident weights were taken at the beginning of the month on bath days and recorded in the weight binder that was kept in the tub room on each unit. Additionally, they identified that the night shift PSW staff were responsible for entering the monthly weights of each resident into the resident's electronic weight record.

During an interview with RPN #141, they reported to Inspector #621 that the registered nursing staff (RPNs and RNs) were responsible for entering resident weights into MED e-care by the 15th of each month; and informing PSW staff at shift change report of any residents who still required their weights to be taken.

Inspector #621 reviewed the home's policy titled "Weight Changes", approved November 2017, which identified that residents were to be weighed monthly by the

PSW on their first bath day, or by the seventh day of the month; and that monthly weights were to be entered into the vitals section on MED e-care by registered staff.

During an interview with the Administrator, they identified to Inspector #621 that it was their expectation that PSW staff were weighing residents within the first week of each month according to the resident's bath schedule; and that these weights were being entered by the 15th of the month into the residents' electronic weight records on MED e-care by either the RPN or RN staff.

The Administrator reviewed the monthly weight records from MED e-care over the previous six months with Inspector #621 and confirmed that monthly weights were not documented for September, October, November and/or December of 2017, as follows:
- resident #001 did not have two of the four monthly weights documented;
- resident #026 did not have one of the four monthly weights documented;
- resident #027 did not have two of the four monthly weights documented;
- resident #028 did not have three of the four monthly weights documented;
- resident #029 did not have one of the four monthly weights documented;
- resident #030 did not have two of the four monthly weights documented;
- resident #031 did not have one of the four monthly weights documented;
- resident #032 did not have two of the four monthly weights documented; and
- resident #033 did not have one of the four monthly weights documented. [s. 30. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance that ensures that any actions taken with respect to a resident under a program, focusing on the nutrition care and hydration program's monthly weight monitoring system, including assessments, reassessments, interventions and the resident's responses to interventions are documented, to be implemented voluntarily.

WN #12: 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 his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

Complaints were received by the Director related to the provision of personal support services, including baths, to resident #012. The complaints alleged that the home did not have sufficient staffing to provide adequate personal support services to the residents in the home.

During an interview with Inspector #625, anonymous complainant #129 stated that the home was short of staff every weekend and, more recently, weekdays as well. They stated the lack of staff resulted in residents in the home not receiving personal care, including baths, as required and that resident #012 had asked the home's management if they could change the date of their bath as they were concerned that they would not receive baths if they continued to be scheduled as they were.

(A) During an interview with resident #012, they stated that they had missed baths, even those scheduled during the week. They further stated that the baths were missed when the home was short staffed, that they had missed multiple baths in one month in 2018, and specifically recalled missing their bath scheduled for a date in the winter of 2018. The resident stated that they were told by the staff that the bath could not be provided due to short staffing.

Inspector #625 reviewed the current bath schedule for the floor and home area the resident resided on, and resident #012's current care plan, both of which identified the resident was scheduled to have baths twice weekly. The care plan identified that the resident required the assistance of staff during bathing.

The resident's Point of Care Flowsheet for a month in 2018, did not indicate that baths were documented to have occurred on five out of nine, or 56 per cent, of resident #012's scheduled bath days in that month, including the date identified by the resident. The baths were not coded as refused on the Flowsheet and there were no progress notes documented pertaining to the unsigned baths.

(B) During an interview with resident #069, they stated that they had baths scheduled for two days each week. They also stated that they had missed one of their baths four weeks in a row beginning in December 2017. The resident stated that the staff had informed them they could not be provided with their baths because the home was short staffed on those days. The resident also stated that the baths had not been made up for the four weeks and they only had one bath a week for four consecutive weeks.

Inspector #625 reviewed the current bath schedule for the floor and home area the resident resided on, and resident #069's current care plan, both of which identified the resident was scheduled to have baths twice weekly. The care plan identified that the resident required the assistance of staff during bathing.

The resident's Point of Care Flowsheet for a month in 2018, did not indicate that baths were documented to have occurred on eight out of nine, or 89 per cent, of resident #069's scheduled bath days in that month. The baths were not coded as refused on the Flowsheet and there were no progress notes documented pertaining to the unsigned baths. The resident had only one documented bath listed.

During an interview with PSW #106, they stated that they had not provided resident #069 with a bath on a date during that month in 2018, as the floor had been short staffed one to two PSWs throughout the shift [out of a PSW complement of six].

During an interview with PSW #110, they stated that the home had worked short on two consecutive dates in the winter of 2018, and, on the shift they worked, they believed that no baths had been provided to residents.

During interviews with PSWs #104, #105, #106, #108, #114, #130, #131 and #132, they stated that residents did not receive baths when the home was short staffed.

Inspector #625 reviewed a document detailing the home's staffing deficiencies for January 2018, provided by Staffing Coordinator #109. The Inspector noted that the home had been working with less than the full PSW staff complement on 84 per cent of the day shifts and 87 per cent of the evening shifts in January 2018.

During an interview with the Administrator, they stated that residents should be receiving baths twice per week, if that was their preference and frequency indicated in their plan of care. [s. 33. (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 that ensures that each resident of the home is bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition, to be implemented voluntarily.

WN #13: 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 each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

Complaints were received by the Director related to the impact that staffing shortages had on the provision of care to residents. One complainant alleged that the home had many staffing shortages and were working short on a daily basis which resulted in prolonged periods where staff did not respond in a timely manner to residents' requests for assistance, including responding to the personal care needs of resident #037 specifically.

During an interview with Inspector #625, resident #037 stated that they used their call bell to obtain staff assistance with toileting and waited for ten minutes for assistance to toilet on a date in the winter of 2018, which was a long time for them to wait based on their specific toileting needs. The resident also stated that they repeatedly waited for staff assistance to toilet and had waited for approximately 45 minutes for staff to respond to their call bell on another date during the same month, when they had required assistance with toileting.

A review of resident #037's current care plan, with a focus on toileting, identified that the resident required staff assistance with toileting.

During interviews with PSWs #104, #105, #106, #108, #114, #130, #131 and #134, they acknowledged that residents waited for staff to respond to their call bells, and that call bells rang for longer periods of time, when staff worked with less than the full complement of PSWs.

A review of a document outlining staffing deficiencies provided by the Staffing Coordinator #109, identified that the floor where resident #037 resided operated

with less than the full PSW complement for 23 day shifts in January 2018, or 74 per cent of the day shifts in January; and 21 evening shifts in January 2018, or 68 per cent of the evening shifts in January.

Inspector reviewed a Responder 4000 Reporting Software report for call bell response time for resident #037 over 19 dates in the winter of 2018. The report indicated that, on one of the dates identified by resident #037, their call bell rang in excess of 25 minutes. The Inspector also noted that the report identified:
- on the first date reviewed a call bell response time was in excess of 22 minutes;
- on the third date reviewed a call bell response time was in excess of 18 minutes;
- on the sixth date reviewed a call bell response time was in excess of 25 minutes;
- on the ninth date reviewed a call bell response time was in excess of 27 minutes;
- on the 13th date reviewed a call bell response time was in excess of 25 minutes; and
- on the 17th date reviewed a call bell response time was in excess of 23 minutes.

During an interview with Inspector #625, the home's Administrator, they stated that, when a resident required assistance with toileting, the assistance should be prompt to meet their needs and promote 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 that ensures that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
1. Staff apply the physical device in accordance with any manufacturer's instructions. O. Reg. 79/10, s. 110 (1).

s. 110. (1) Every licensee of a long-term care home shall ensure that the following requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act:
2. The physical device is well maintained. O. Reg. 79/10, s. 110 (1).

s. 110. (7) Every licensee shall ensure that every use of a physical device to restrain a resident under section 31 of the Act is documented and, without limiting the generality of this requirement, the licensee shall ensure that the following are documented:
7. Every release of the device and all repositioning. O. Reg. 79/10, s. 110 (7).

Findings/Faits saillants :

1. The licensee has failed to ensure that, with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, staff applied the physical device in accordance with any manufacturer's instructions.

On a date in the winter of 2018, Inspector #625 observed resident #035 using a mobility aid with a safety device engaged, with a portion of the device not applied correctly.

On two additional dates in the winter of 2018, Inspector #621 observed resident #035 using their mobility aid and noted a safety device in use that was not correctly applied. Additionally, the safety device was loose in spite of it being engaged.

During an interview with RN #103, they reported to Inspector #621 that resident #035 used a safety device and a mobility aid, and the safety device acted as a restraint. The RN reported that the resident's safety device was to be applied in a specific manner when it was engaged.

During interviews with the Inspector, both RN #103 and the DOC observed resident #035 using their mobility aid and reported that the safety device was incorrectly applied, and the device was loose.

During an interview with the resident #035's safety device manufacturer's representative #144, of Power Plus Mobility, they reported to Inspector #621 that the safety device was to fit the resident in a specific manner when the resident used it with their mobility aid. The manufacturer's representative confirmed to the Inspector that if the device was instead found to be loose and in the manner observed by the Inspector, the device would not be applied correctly.

During an interview with the DOC, they identified to Inspector #621 that it was their expectation that PSWs who were responsible for application of safety devices, were applying the devices correctly, and if any issues arose, they would report to the RPN and /or RN for further assessment and direction. [s. 110. (1) 1.]

2. The licensee has failed to ensure that, with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, the physical device was well maintained.

During an interview with PSWs #117 and #111, they reported to Inspector #621 that resident #035 used a safety device as a form of restraint. PSW #117 reported however, that a piece on resident #035’s the device had broken off the device weeks prior, and required repair. The PSW identified that the device could still be applied but that disrepair was present. They further indicated that registered staff were notified of the issue on a date in winter of 2018, with follow up made with resident #035’s substitute decision maker (SDM) that same day, and the SDM requested the home have the device fixed. PSW #117 stated that a representative from Motion Specialties came into the home weekly and followed up on any entries added to a form found in the Motion Specialties binder, located at the nursing station. However, the PSW reported to the Inspector that despite the direction from the SDM to have the device repaired, as of eight days following the direction from the SDM, registered staff had not yet made an entry in the Motion Specialties binder to notify them of resident #035’s device's disrepair.

Inspector #621 reviewed documentation including the unit's shift change report log which identified that on the day shift of a date in the winter of 2018, resident #035’s safety device was documented as being broken. On the evening shift on the same date, documentation in the shift change report identified that resident #035’s SDM

wanted the device fixed. The Inspector found no record of a request for repair of resident #035's safety device on or after this date, in the Motion Specialties binder.

During an interview with the DOC, they reported to Inspector #621 that it was their expectation that if a resident's safety device used as a restraint was in disrepair, there would be communication of the issue between unit staff; the resident and/or SDM would be notified; and if the restraint was to be repaired or replaced, that the service provider of that resident's mobility aid, for which the safety device was required, would be notified. The DOC confirmed, regarding resident #035's mobility aid, Motion Specialties should have been notified of any disrepair, and if the issue was not emergent, it should have been recorded in the Motion Specialties binder on the unit for weekly follow up. The DOC viewed resident #035's mobility aid with Inspector #621 and acknowledged the safety device restraint had a component of the device missing, and required repair. The DOC confirmed that the issue of repair of resident #035's safety device had occurred on the date in the winter of 2018, but that there was no record that Motion Specialties had been notified to follow up as of eight days later. [s. 110. (1) 2.]

3. The licensee has failed to ensure, with respect to every use of a physical device to restrain a resident under section 31 of the Act, every release of the device and all repositioning were documented.

During an interview with RN #103, they reported to Inspector #621 that resident #035 used a safety device which acted as a restraint.

On a date on the winter of 2018, from 1300 hrs to 1600 hrs, Inspector #621 observed resident #035 using their mobility aid, with the safety device applied, with no release of the device or repositioning completed by PSW or registered nursing staff during this time.

During interviews with PSW #112, they reported to Inspector #621 that when a restraint was being utilized with a resident, PSW staff were responsible for repositioning the resident and release/reapplication of the restraint every two hours when the restraint was applied, as well as documenting release of the device and repositioning in the resident's PSW MED e-care Downtime Form. The PSW confirmed resident #035 used a safety device restraint and that on the date observed by the Inspector, from 1300 hrs to 1600 hrs, there was an absence of documentation that resident #035's safety device restraint was release/reapplied with the resident repositioned at least every two hours. Additionally, PSW #112

reported that there was an absence of documentation to support device release and repositioning between 0800 hrs and 1500 hrs on multiple dates during January 2018, when this resident usually used their mobility aid with the safety device restraint applied.

During an interview with RN #102, they reported to Inspector #621 that PSW staff were to reposition and reapply resident #035's restraint, as well as document that this was completed every two hours on the PSW MED e-care Downtime Form. On review of resident #035's restraint monitoring form for January 2018, the RN confirmed that there were several gaps in documentation over the month.

During an interview with the DOC, they reported to Inspector #621 that it was their expectation that PSW staff were monitoring restraints hourly when applied, and reapplying the restraint with repositioning of the resident every two hours. Additionally, the DOC indicated that PSW staff were to document the application, release/repositioning/reapplication, and removal the of the restraint on the PSW MED e-care Downtime Form. On review of resident #035's restraint record for January 2018, the DOC confirmed that there were gaps in the documentation that would need to be addressed. [s. 110. (7) 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 that ensures that specific requirements are met with respect to the restraining of a resident by a physical device under section 31 or section 36 of the Act, including that staff apply the physical device in accordance with any manufacturer's instructions and that the physical device is well maintained, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 114. Medication management system

Specifically failed to comply with the following:

s. 114. (2) The licensee shall ensure that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home. O. Reg. 79/10, s. 114 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that written policies and protocols were developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home.

Inspector #625 observed a specific medication, which was a controlled substance, stored in a medication cart for the use of resident #062. The medication was contained in a bottle labelled with the resident's name as well as over 60 individually drawn up syringes.

During an interview with RPN #107, they stated that resident #062 used a particular medication which was obtained via Canada Post from out of province and was supplied by the resident's family. The RPN identified that the individual syringes of the medication were drawn up by the DOC and a member of the registered nursing staff and were included in the narcotics count as the number of syringes present. The RPN identified that resident #062's order for the medication was currently on hold.

Inspector #625 reviewed resident #062's chart with a focus on the medicaion use which included:
- two "Medical Documents", identifying patient information and health care practitioner information, including the period [duration] of use, daily usage dose and usage purpose;
- a shipment confirmation document from Canada Post; and
- the two most recent physician's orders for use dated in the winter of 2018.

During an interview with the DOC, they stated that resident #062 was admitted to

the home years prior, used the medication prior to admission to the home and had used the medication in the home. The DOC acknowledged that the medication was not supplied by the home's pharmacy service provider but was obtained from an out of province source via mail that arrived to the front desk of the multi-purpose building. The DOC confirmed that the individual syringes of the medication had been drawn up by the home's staff. The DOC stated that the home did not have an approved policy in place for the use of the medication, despite the unique process required for it's acquisition, dispensing, receipt and storage, but identified that the home was aware that a policy was required and the home was working through the process of developing a policy.

During a phone interview with the home's Medical Director, physician #121, they confirmed that, although resident #062 had been using the medication while residing in the home, the licensee did not have an approved policy addressing use of the specific medication by residents as the licensee's Medical Advisory Committee had yet to approve a policy.

During an interview with the Administrator, they acknowledged that the home had been involved in developing a policy regarding use of the specific medication, but that they did not currently have a policy approved for use. [s. 114. (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 that ensures that written policies and protocols are developed for the medication management system to ensure the accurate acquisition, dispensing, receipt, storage, administration, and destruction and disposal of all drugs used in the home, to be implemented voluntarily.

WN #16: 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. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and documented results of this screening were available to the licensee.

During review of the Long-Term Care Home Licensee Confirmation Checklist Infection Prevention and Control (IPAC) completed by the home's Administrator and IPAC Lead #142, Inspector #621 identified that the home had responded that each resident admitted to the home had not been screened for tuberculosis (TB) within 14 days of admission unless the resident had already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee.

Inspector #621 reviewed the home's policy titled "Tuberculosis Management – IC 1 -66", approved January 1, 2017, which identified that "as per the Long-Term Care Homes Act (2007), each resident must be screened for TB within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available".

During an interview with the home's Administrator, they reported to Inspector #621 that the home had been in the process of working with each resident's physician to determine whether residents admitted to the home had been screened for TB. Subsequently, the Administrator provided Inspector #621 with a line list of 12 residents and confirmation that residents #008, #011, #013, #014, #016, #017, #018, #019, #021, #022, #023, and #024 had not had TB tests completed since their admission. Additionally, the Administrator was unable to provide documentation at the time of the inspection to support that the same residents had been screened for TB within 90 days prior to their admission to the home. [s. 229. (10) 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 that ensures that immunization and screening measures are in place including screening each resident admitted to the home for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with LTCHA, 2007, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the home, furnishings and equipment were kept clean and sanitary.

On a date in the winter of 2018, Inspector #625 observed resident #035's mobility aid soiled with debris on components of the mobility aid and attached safety device; and resident #036's mobility aid soiled with debris embedded into a component of the aid.

On another date in the winter of 2018, Inspector #621 observed resident #035's mobility aid in the same condition with embedded debris on one of its components, and stains on another component and attached safety device; and resident #036's mobility aid soiled with the same debris on one of its components.

During interviews with PSW #112 and RN #103, they reported to Inspector #621 that night shift PSW staff on each unit were responsible for cleaning resident ambulation equipment, including the type of mobility aids used by residents #035 and #036, using a machine washer. The PSW and RN identified that residents' ambulation equipment was cleaned once monthly, or more often if visibly soiled, and documentation of the cleaning would be completed on the home's Wheelchair/Walker Cleaning schedule. Additionally, PSW #112 indicated that if a resident's ambulation equipment required spot cleaning between monthly scheduled cleaning, or if the resident had an electric wheelchair, then it was cleaned by hand instead using the hospital disinfectant solution, warm water and a clean cloth. The PSW reported that seat cushion covers would be sent to laundry for cleaning.

PSW #112 reviewed the Wheelchair/Walker Cleaning schedule for November and December 2017, and January 2018, and identified to Inspector #621 that resident #035's mobility aid was recorded as having been last cleaned on a date in November 2017. The PSW also confirmed that according to the cleaning schedule, resident #036's wheelchair was last cleaned on a date in January 2018. Additionally, PSW #112 confirmed with the Inspector that there were 36 out of 56, or 64 per cent, of residents on one of the floors who were scheduled to have their wheelchairs or walkers cleaned, which were not documented as completed. Further, the PSW reported that cleaning of wheelchairs and walkers may not be getting done, as there was only one night PSW scheduled for each unit of 56 residents, and one night PSW float scheduled from 1100 hrs to 0300 hrs to assist on both units of the home.

On a date in the winter of 2018, PSW #112 and RN #103 observed resident #035 and #036's mobility aids prior to a meal service and confirmed to Inspector #621 that both mobility aids were soiled with debris and stains and should have been cleaned.

During an interview with the Administrator, they reported to Inspector #621 that it was their expectation that resident wheelchairs and walkers were cleaned monthly per the PSW night shift cleaning schedule, or more often if visibly soiled. The Administrator also reported that they expected PSW night staff to document completion of the cleaning on the schedule provided in the PSW night shift binder. [s. 15. (2) (a)]

WN #18: The Licensee has failed to comply with LTCHA, 2007, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that, if a written complaint concerning the care of a resident or the operation of the long-term care home was received by the licensee, it was immediately forwarded to the Director.

A CIS report was received by the Director in the winter of 2018. The report identified that resident #068 was neglected the previous date, over 22 hours earlier. The report was amended to identify that, two days after the incident occurred, an email was received from family member #136 asking that their complaint related to the incident be shared with the MOHLTC and included one paragraph that identified the family member's complaint related to the failure of the home to provide an intervention related to continence to the resident. The report identified the family member's complaint as one related to the resident's mobility aid, which they used throughout the day, and had been found soiled with a body fluid. The family member took videos of a portion of the mobility aid.

During a phone interview with family member #136, they stated that they had emailed a complaint to the home's DOC and Administrator when they discovered the incident, on the date it had occurred. They stated that the complaint was related to the home's failure to provide a continence related intervention to the resident all day resulting in the resident having used a mobility aid that was soiled with a body fluid. The family member stated that they spoke to the DOC and Administrator the day following the incident, when they were asked if they wanted the home to include the family member's email complaint in a CIS report to the

MOH, and had consulted with their family and decided to include the complaint in the CIS report. The family member stated they had sent previous emails to the home with complaints about resident #068's care and was not aware that any were send to the Director. At that time the family member also commented on another complaint they had related to the operation of the home with respect to soiling of a shared bathroom with a body substance and housekeeping services. This was the first knowledge the Inspector had of the additional content of the complaint.

Inspector #625 reviewed an email from family member #136 to the home's Administrator on the date of the incident. The email was received, after being requested by the Inspector, 37 days after it had been submitted to the home. It contained additional information regarding the family member's complaint that was referred to in the CIS report to the Director. In addition to the complaint about the incident, the email also identified that the resident had not been provided with interventions related to continence on other recent occasions; they had been notified that staff shortages was why the resident had not had the interventions performed on those occasions and that one of the interventions was an essential service. The complaint also identified that the resident's shared bathroom had been soiled with a body substance from another resident on more than one occasion and that the family member had cleaned up the substance but was worried about infection control practices and suggested the home put in place a person on call in housekeeping during the evening to address cleaning needs related to safety/infection control.

During a phone interview with the Administrator, they acknowledged that the email sent by family member #136 the date of the incident, was a written complaint that met the criteria to be forwarded to the Director, that they did not identify it as such at the time and that they had only included a portion of the written complaint in the CIS report after asking the family member if they wanted it to be included in the report. [s. 22. (1)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services programs referred to Ontario Regulation 79/10, s. 31 (1) (a) and (b).

Complaints were received by the Director alleging that the home had insufficient staffing levels to provide adequate nursing and personal support services to the residents in the home.

A review of an untitled document provided by the home's Administrator to Inspector #625 related to the home's staffing plan, identified that the home did not have a staffing plan in place that met the legislative requirements.

During an interview with Inspector #625, the home's Administrator stated that they were not able to provide the Inspector with the home's written staffing plan referred to in Ontario Regulation 79/10, s. 31 (2). The Administrator acknowledged that the home did not have a written staffing plan in place that met the requirements for a staffing plan as identified in O. Reg. 79/10, s. 31 (3) including:
- providing for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and Regulation;
- setting out the organization and scheduling of staff shifts;
- promoting continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident; and
- having been evaluated and updated at least annually in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices. [s. 31. (2)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care
Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included physical assistance or cueing to help a resident who could not, for any reason, brush his or her own teeth.

Complaints were received by the Director related to the provision of personal support services to residents in the home. One complaint identified deficiencies in the personal care provided to resident #012 related to the staffing levels.

During an interview with anonymous complainant #129, they stated that the home was short of staff and that the lack of staff resulted in residents in the home not receiving the personal care they required.

During an interview with resident #012, they stated that, due to a medical condition, they required the assistance of staff to assist them with oral care. The resident stated that staff had not been providing this assistance for approximately three to four weeks.

A review of resident #012's care plans in effect in January and February 2018, identified that staff were to ensure and monitor the resident's oral care ability and assist the resident with their oral care.

During an interview with PSW #115, they stated that they were very familiar with resident #012, the resident should have specific assistance provided to them by staff with respect to oral care and the resident would be accurate when they stated it had not been completed for them for three to four weeks.

During an interview with PSW #133, they stated that they had provided personal care to resident #012 multiple times over previous weeks. The PSW stated that they had not read the resident's Kardex [which identified the resident required staff to provide assistance to the resident with oral care] for a while as the floor had been short staffed, they were not aware that the resident required the assistance with oral care, and they had not provided the specific assistance with oral care when they had provided care to the resident.

During an interview with the Administrator, they stated that residents should be receiving personal care as per their plans of care. [s. 34. (1) (b)]

WN #21: The Licensee has failed to comply with LTCHA, 2007, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

s. 57. (2) If the Residents' Council has advised the licensee of concerns or recommendations under either paragraph 6 or 8 of subsection (1), the licensee shall, within 10 days of receiving the advice, respond to the Residents' Council in writing. 2007, c. 8, s. 57.(2).

Findings/Faits saillants :

1. The licensee has failed to ensure that if the Residents’ Council had advised the licensee of concerns or recommendations, the licensee within ten days of receiving the advice, responded to Residents’ Council in writing.

During an interview with Inspector #621, an active member of the Residents' Council, resident #006, reported that some of the home’s management responded verbally to concerns or recommendations raised by residents when in attendance at Residents’ Council meetings, but that written responses were not provided within ten days of any specific issues being raised at Council meetings.

Inspector #621 reviewed copies of the Residents’ Council meeting minutes from October 23, 2017, and noted the following recommendations raised by Residents’ Council members:
- if PSW staff assist Dietary Aides, they wear hair nets; and
- vegetable dishes be served warm and less watery.

The Inspector further identified that there was no documented response from the licensee to Residents’ Council within ten days to either of the identified recommendations brought forward from Residents' Council meetings.

During an interview the Resident Counsellor, who served as the Assistant to Residents’ Council, reported to Inspector #621 that when home’s management staff were in attendance at Residents’ Council meetings, they addressed resident recommendations or concerns verbally at that time. They confirmed that a written response from the home to the Residents’ Council regarding each identified recommendation had not been provided to the Council within ten days.

During an interview with the Administrator, they identified to Inspector #621 that it was their expectation that a written response was provided to Residents’ Council for any concerns or recommendations brought forward by the Council, as per legislative requirements. [s. 57. (2)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 122. Purchasing and handling of drugs

Specifically failed to comply with the following:

s. 122. (1) Every licensee of a long-term care home shall ensure that no drug is acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug,
(a) has been prescribed for a resident or obtained for the purposes of the emergency drug supply referred to in section 123; and O. Reg. 79/10, s. 122 (1).
(b) has been provided by, or through an arrangement made by, the pharmacy service provider or the Government of Ontario. O. Reg. 79/10, s. 122 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was acquired, received or stored by or in the home or kept by a resident under subsection 131 (7) unless the drug had been prescribed for a resident or obtained for the purpose of the emergency drug supply referred to in section 123.

On a date in the winter of 2018, Inspector #625 observed a controlled substance in a medication room fridge for resident #021 with directions that identified the medication was to be used for a limited period of time, which ended 83 days prior.

The Inspector reviewed the most recent physician's order dated in the fall of 2017, for the medication for resident #021 that read the medication could be administered for a limited period of time.

During an interview with RPN #107, they stated that the order was only valid for a limited period of time, there was no current order for the medication for resident #021 and the medication should have been disposed of.

During an interview with the DOC, they reviewed the physician's order for the medication for resident #021 dated in the fall of 2017, and stated that the medication had only been ordered for a limited period of time ending 83 days earlier, and that there was no current order for the medication in effect. [s. 122. (1) (a)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During an interview with Inspector #625, resident #010 stated that they applied a medicated topical cream to a part of their body and that it was effective. The resident stated they kept the cream in their room, which was observed by the Inspector, and used it as needed

On two additional dates, the Inspector again observed the medicated topical cream container in the resident's room.

On a date in the winter of 2018, the Inspector was not able to locate an entry related to the use of the medicated topical cream on resident #010's current eMAR.

During an interview with RN #102, they stated that resident #010 did not have an order for the cream and the RN thought that an order was not required as the item was obtained from government stock.

During an interview with the DOC, they attended resident #010's room with Inspector #625 and observed the medicated topical cream in the resident's room. Resident #010 stated to the DOC and the Inspector that they applied the cream to multiple parts of their body, including any part of their body that required it and that it was effective. The resident stated they informed the staff when they ran out so the staff could provide more to the resident. The DOC stated to the Inspector that an order for the use of the medicated topical cream was required and that the application of the cream would be required to follow the prescriber's directions for use.

During interviews with the Administrator, they stated that they had consulted with RN #103 who informed the Administrator that they did not believe an order was required for residents to use government stock items. The Administrator also stated that they had verified with the home's RN (EC) that an order for use of medicated topical treatments was required and acknowledged that the use of the specific medicated topical cream would require a prescription for use, which identified details such as the site(s) and frequency of use, as was the case with other government stock items. [s. 131. (1)]

Issued on this 18 day of May 2018 (A2)

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

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Telephone: (705) 564-3130
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Amended Public Copy/Copie modifiée du public de permis

Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by STEPHANIE DONI (681) - (A2)

Inspection No. / No de l'inspection : 2018_703625_0001 (A2)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 000668-18 (A2)

Type of Inspection / Genre d'inspection: Resident Quality Inspection

Report Date(s) / Date(s) du Rapport : May 18, 2018;(A2)

Licensee / Titulaire de permis : St. Joseph's Care Group
35 North Algoma Street, P.O. Box 3251, THUNDER BAY, ON, P7B-5G7

LTC Home / Foyer de SLD : Bethammi Nursing Home
63 Carrie Street, THUNDER BAY, ON, P7A-4J2

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Janine Black

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 St. Joseph's Care Group, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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.
2. The outcomes of the care set out in the plan of care.
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Order / Ordre :

The licensee must be compliant with s. 6 (9) 1 of the Long-Term Care Homes Act (LTCHA), 2007.

The licensee shall ensure that the provision of the care set out in the plan of care is documented.

The licensee shall specifically:
- Conduct an audit of resident #027, #029, #035 and #038's health care records to identify the records on which staff had failed to document the care provided;
- Identify the causes of the failure to document the care provided and address them;
- Establish and implement a routine auditing schedule of the documentation of the provision of care to residents including auditing of Treatment Administration Records (TARs), weekly wound assessments, Wound Assessment Tools, Flowsheets, Bathing Reports, Dietary Reports and all components of residents' plans of care in which documentation of the provision of care is required; and
- Maintain written records of the audits conducted, the findings and the actions taken to address any deficiencies in the documentation.

Grounds / Motifs :

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

Complaints were received by the Director related to the impact that staffing shortages had on the provision of nursing and personal care services to residents. One complainant alleged that the home had many staffing shortages and the home's staff were working with less than a full complement of staff on a daily basis.

(A) During an interview with PSW #110, they stated to Inspector #625 that the floor they worked on was short two PSWs over a weekend in January 2018, and that no documentation of the care provided that shift was completed by PSWs as a result.

(B) During several interviews with PSW #106, they stated that they had not been able to complete PSW charting on a particular date in December 2017, due to insufficient PSW staffing. They also stated that they had not been able to complete PSW documentation for multiple residents during a shift on a particular date in February 2018, and had only documented one limited item that occurred, due to insufficient staffing.

Inspector reviewed Dietary Reports for a particular date in February 2018, with a focus on meals, snacks and beverages offered during the shift identified by PSW #106, for the residents PSW #106 identified they had been required to provide care to and document on that shift. None of the residents had any documented meal, beverage or snack intervention details documented, including the amount of intake, if they were on a leave of absence (LOA), refused or were sleeping.

The Inspector also reviewed a floor's PSW Flowsheets for the specific shift on date in February 2018, for the multiple residents indicated above, and identified that 89 per cent of the residents did not have any documentation completed on the flowsheets including: bladder and bowel continence and function, oral care, cognitive pattern, mood and behaviour, special needs (glasses, hearing aids, sleep/rest), assistive devices/PASDs or pain symptoms.

(C) Inspector #625 reviewed a specific floor's Bath Schedules Home Areas #1 and #2, and identified 55 residents scheduled for baths one to two times weekly.

A review of PSW bathing flowsheet reports for January 2018, identified that, of the residents on that floor:
- 11 had one bath documented;
- 16 had two baths documented;
- 11 had three baths documented;
- four had four baths documented;
- five had five baths documented;
- one had six baths documented;
- one had seven baths documented; and
- one had eight baths documented.

The Inspector reviewed another specific floor's Bath Schedules Home Area #1 and #2, and identified 55 residents scheduled for baths one to two times weekly.

A review of PSW bathing flowsheet reports for January 2018, identified that, of the residents on that floor:
- 22 had zero documented baths;
- 28 had one bath documented;
- five had two baths documented; and
- one had three baths documented.

The review of the PSW bathing flowsheet reports for January 2018 identified that no resident had 100 per cent of their scheduled baths documented, whether provided, refused or on a LOA.

During an interview with PSW #134, they reviewed the PSW flowsheet bathing reports that identified multiple residents had baths documented only once or twice in January 2018. The PSW stated if the floor was one PSW short on those dates, the baths were "probably not charted", but if the floor was two PSWs short the baths were "probably not given".

(D) PSW #123 identified that PSW documentation was not completed on a particular shift on a date in February 2018, as one of the floors was short two PSWs leaving four PSWs to provide personal care to 56 residents. (625)

2. Resident #027 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #027's RAI-MDS assessment dated a particular date in the fall of 2017, which identified the resident had multiple areas of altered skin integrity.

Five days into the current month in the fall of 2018, at 1700 hours, Inspector #625 observed the PSW TARs for that month for one of the floors to be stacked in a pile at the nursing station, unsigned. The TARs contained skin and wound care interventions, as well as other interventions such as falls prevention interventions, which the PSWs were required to implement and document on when completed. The interventions listed on resident #027's current TAR, including several interventions related to altered skin integrity, did not contain documentation to identify they had been completed various times each day.

During an interview with PSW #106, they stated that the TARs listed the interventions that PSWs were required to provide to residents and PSWs were to document on the TARs when the interventions listed were completed. The PSW also stated that PSWs were required to complete a treatment related to resident #027's altered skin integrity which would need to be documented on the resident's TAR by the PSWs.

During an interview with PSW #123, they acknowledged that, although it was the evening shift five days into the current month, the TARs had not been filed in PSW assignment binders for PSWs to refer to when providing care and no treatments or interventions listed in the TARs (including the treatments for altered skin integrity) had been documented as completed for any of the residents on that floor [on which half of the home's 112 residents resided].

During an interview with RN #102, they acknowledged that the TARs for one of the floors had not been filed in the PSW binders as of the evening shift five days into the current month, and that staff had not documented any care provided on the TARs up to that time.

Five days into the current month, at 1700 hrs, during an interview with the Administrator, they acknowledged that the current month's TAR for one of the floors had not been placed in the PSW binders for PSWs to refer to, or to document on

when care had been provided as listed, and that some interventions on the TAR had been completed but had not been signed for by the PSWs. (625)

3. Resident #029 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #029's RAI-MDS assessment dated the fall of 2017, which identified the resident had altered skin integrity.

A review of the instructions for completion of the "Wound Assessment Tool" identified that staff were to complete specific documentation on the tool with each dressing change.

A review of the resident's "Wound Assessment Tool" on a particular date in the winter of 2018, identified that the treatment for the resident's altered skin integrity was to occur at specific frequencies. The last two documented treatments were dated 13 and seven days prior, which did not reflect the treatment had been had been completed at the frequency specified on the tool.

During interviews with PSWs #106 and #123, they stated that resident #029's treatment was completed at a specified frequency due to an activity that occurred.

During an interview with RPN #124, they stated that staff were required to document on the "Wound Assessment Tool" each time resident #029's treatment was completed. The RPN stated that the treatment was to be completed at a specified frequency, and the last recorded treatment was dated a number of days earlier, which was less than the frequency specified.

During an interview with RN #102, they stated the completion of the treatment should be documented on the "Wound Assessment Tool" and that resident #029's treatment had last been documented as completed on a particular date in the winter of 2018. The RN acknowledged that, as the treatment was usually completed at a specific frequency, the staff were not documenting the provision of care set out in the plan of care with respect to resident #029's altered skin integrity. (625)

4. Inspector #621 observed resident #035's bed to have a safety device present.

During a review of resident #035's plan of care, including their current care plan, Inspector #621 identified that one of the falls prevention strategies for this resident included the use of a safety device.

During interviews with PSW #111 and RN #102, they reported to Inspector #621 that PSW staff were responsible for documenting completion of any treatments ordered in the TAR for each of their assigned residents, which included initialing under the corresponding date and time in the TAR, that monitoring of a resident's safety device was completed at least once per shift. Both PSW #111 and RN #102 confirmed to the Inspector that as part of resident #035's plan of care, the resident utilized a safety device as part of their falls prevention strategies.

During a review of resident #035's TAR for a month in the winter of 2018, both PSW #111 and RN #102 confirmed that there was no documentation that monitoring had been completed for resident #035's safety device at various times on multiple dates. Additionally, RN #102 confirmed to the Inspector that provision of care as set out in the plan of care with respect to ensuring that resident #035's safety device was operational each shift, was not documented as required. (621)

5. Inspector #621 observed resident #038's bed to have a safety device present.

A review of resident #038's plan of care, including their most current care plan, identified that one of the falls prevention strategies for this resident included the use of the safety device.

During interviews with PSW #111 and RN #102 they reported that PSW staff were to document completion of any treatments ordered in the TAR for each of their assigned residents, which included initialing under the corresponding date and time in the TAR that monitoring of a resident's safety device was completed at least once per shift. Both the PSW and the RN confirmed that, as part of resident #038's plan of care, the resident utilized the safety device as one of their falls prevention strategies.

During a review of resident #038's TAR for a month in the winter of 2018, both PSW #111 and RN #102 confirmed that there was no documentation that monitoring had been completed for resident #038's safety device at various times on multiple dates. Additionally, RN #102 confirmed that the provision of care as set out in the plan of care with respect to ensuring that resident #038's safety device was operational each shift, had not been documented as required.

During RQI #2017_463616_0007, commencing on May 15, 2017, a VPC was issued.

The decision to issue a compliance order was based on the severity which indicated the potential for actual harm to occur, and the scope, which indicated that the noncompliance was widespread. In addition, the home's compliance history identified a history of noncompliance specific to this area of the legislation. (621)

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

Jun 30, 2018(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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) (a) of the LTCHA.

The licensee shall ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents.

The licensee shall specifically:
- Conduct a wholesome review of the allocation of nursing staff employed in the home, to ensure it meets the assessed needs of residents; where deficiencies are identified, take actions to address the staffing deficiencies;
- Review and revise the workload assignments of the RPN staff, engaging and consulting with the staff throughout the process, with a focus on establishing routines and assignments that can be reasonably foreseen to meet the nursing needs of the residents in the home;
- Audit the revised assignments to ensure the nursing services are meeting the needs of the residents in the home; and
- Maintain records of actions taken with respect to the above.

Grounds / Motifs :

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

(A) During a review of residents' #027, #029 and #033 health care records by Inspector #625, it was identified that resident #029 had not received a weekly wound assessment completed by a member of the registered nursing staff since a specific month in the fall of 2017, and residents #027 and #033 had not received weekly wound assessments completed by a member of the registered nursing staff since another specific month in the fall of 2017, although all three residents had current areas of altered skin integrity.

During an interview with RN #103, they stated that staff had not been completing any form of weekly wound assessment for the residents as they did not have enough time in their shift to do so, and that staff generally did not have time to complete wound assessments, chart them, or adhere to a daily schedule for wound assessment charting.

Refer to Written Notification (WN) #4, findings #1, #2 and #3, for details.

(B) During a review of resident #033's health care record by Inspector #625, it was identified that a treatment related to continence for resident #033's was completed nine days after the scheduled date.

During an interview with RN #103, they stated that they had completed the treatment nine days late due to staffing constraints with the registered nursing staff. The RN stated that they attempted to complete the continence related treatments within a few days of the due date, in general.

Refer to WN #1, finding #3, for details.

(C) Inspector #625 had observed the practice of an RPN administering a specific medication to a resident, in a specific manner, in the dining room.

During interviews with RPNs #107, #118, #119 and #120, they stated that they administered the specific medication to residents in the dining rooms. Three RPNs identified that the current RPN workload assignment in the home did not provide sufficient RPN resources, when considering the time required to relocate residents already seated in the dining room to another location, to administer the medication

elsewhere for the privacy of the residents.

Refer to WN #8, finding #2, for details.

(D) Inspector #625 observed an RPN fail to maintain the confidentiality of personal health information (PHI) contained in the MAR.

During interviews with RPNs #107, #118 and #119, they stated that they did not have time to close or lock each resident's eMAR when stepping away from the medication cart due to time constraints involved with medication administration passes in the home. They identified that the current RPN staffing and workload assignment in the home did not provide the RPN the time required to close or lock the eMAR.

Refer to WN #8, finding #3, for details.

(E) Inspector #625 reviewed a staff complement document provided by Staffing Coordinator #109 that identified, when fully staffed, the home had one registered nurse on day, evening and night shifts. The document also identified that the home had one RPN assigned to administer medications per floor [56 residents per floor], on day and evening shifts; one float RPN on day and evening shifts; and one RPN on night shifts; and, as a trial up to March 31, 2018, the home had attempted to implement one additional RPN on the day shift during weekdays.

The document identified that, during the month of December 2017, there were ten day and six evening shifts where the home was short an RPN, resulting in eight shifts where two RPNs, out of three to four RPNs, or 50 to 67 per cent of the scheduled RPNs, were in the home to care for 112 residents. During one of the evening shifts where only two RPNs were in the home, there was also no RN in the home from 1500 hours (hrs) to 1900 hrs. On one night shift, there was no RPN in the home.

The document further identified that, during the month of January 2018, there were:
- 19 day shifts where the home did not have the full RPN complement working, including 14 day shifts, where one or more RPN(s) were missing for the entire 0700 to 1500 hrs shift; and
- nine evening shifts where the home did not have the full RPN complement working, including eight evening shifts where one RPN was absent for the entire 1500 to 2300 hrs shift.

An analysis of the staff complement document determined that there were 17 day

and evening shifts where two RPNs worked during the shift, including 15 shifts, where two RPNs out of three to four RPNs, or 50 to 67 per cent of the RPNs scheduled, worked for the entire shift. There were six night shifts where there was no RPN in the home and one night shift where there was no RN in the home.

During an interview with float RPN #120, they stated that the float RPN did not administer medications when they were the third RPN working between the two floors, but responded to incidents such as falls and completed some treatments, as the RPN responsible for medication administration did not have time to do those things when administering medications to 56 residents.

During an interview with RPN #122, they stated that on a particular date in January 2018, the home only had two RPNs working, and did not have a float or trail RPN working, resulting in two out of four, or 50 per cent of the scheduled RPN positions being unfilled. They identified that, with only two RPNs working that shift, they were required to deal with acute resident incidents, obtain vital signs prior to administration of certain medications, administer medications to 56 residents, participate in rocket rounds (interdisciplinary team huddles), process doctor's orders, etc.

During an interview with the home's Staffing Coordinator #109, they stated that the home struggled with staffing, including RPN staffing, due to empty rotations, sick calls and staff not picking up shifts/over time shifts.

During an interview with the home's Administrator, they stated that RPNs were required to administer medications to 56 residents, even when there was a third/float RPN as they had other assigned duties. The Administrator identified that the home had attempted to implement a trial where an additional RPN would be brought into the home during weekday day shifts to address the challenges the home was experiencing with respect to the staffing and workload challenges of the RPNs. They acknowledged the staffing deficiencies detailed in the staffing complement document and that the home was operating with significant staffing shortages and challenges.

The decision to issue a compliance order was based on the severity which identified the potential for actual harm to occur, and although the home did not have a compliance history directly related to this specific area of the legislation, the scope was widespread and represented a pervasive deficiency within the home. (625)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Jun 30, 2018(A2)

Order # /
Ordre no : 003

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

Pursuant to / Aux termes de :

LTCHA, 2007, 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.

The licensee shall ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents.

The licensee shall specifically:
- Conduct a wholesome review of the allocation of personal support services staff employed in the home, to ensure it meets the assessed needs of residents. Where deficiencies are identified, take actions to address the staffing deficiencies;
- Review and revise the workload assignments of the PSW staff, engaging and consulting with the staff throughout the process, with a focus on establishing routines and assignments that can be reasonably foreseen to meet the personal support needs of the residents in the home;
- Audit the revised assignments to ensure personal support services meet the assessed needs of the residents in the home; and
- Maintain records of the actions taken with respect to the above.

Grounds / Motifs :

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

Complaints were received by the Director related to the provision of personal support services to residents in the home. The complaints alleged that the home did not have sufficient staffing to provide adequate personal support services to the residents in the home.

(A) Five days into the current month in the fall of 2018, at 1700 hours, Inspector #625 observed the PSW TARs for that month, for one of the floors, to be stacked in a pile at the nursing station, unsigned.

During an interview with PSW #123, they stated that staff on the night shift had not had time to file the TARs in PSW binders, and staff on day and evening shifts had not had time to sign the TARs, which is why, for five days, the sheets had not been filed and staff hadn't noticed their absence.

Refer to WN #1, finding #8, for details.

(B) During a review of Point of Care Flowsheets for January 2018, and interviews with the home's staff, it was identified by Inspector #625 that multiple baths had not been provided to residents as per their plans of care.

During interviews with the home's staff, they identified that working with less than the designated staff complement resulted in residents not receiving their scheduled baths.

Refer to WN #12, finding #1, for details.

(C) During an interview with Inspector #625, resident #012 identified that they had not been provided with oral care as per their plan of care.

During interviews with staff, they identified that the failure to provide oral care to the resident as detailed in their plan of care was related to insufficient staffing levels.

Refer to WN #20, finding #1, for details.

(D) During interviews with resident #037, they had identified that they had to wait for extended periods of time for assistance with toileting when the home was short staffed.

During interviews with the home's staff, they identified that, when they had worked with less than the designated staff complement, residents had to wait for longer periods of time for staff to respond to their call bells and provide required assistance to them.

Refer to WN #13, finding #1, for details.

(E) Inspector #625 observed residents #003 and #053 wait in excess of 20 minutes for their call bells to be answered.

A review of the Responder 4000 Reporting Software reports (logs listing the location, time and duration of call bell use) for the residents identified multiple occasions where the residents waited in excess of 19 to 75 minutes for their call bells to be responded to.

During interviews with the home's staff, they identified that working with less than the designated staff complement resulted in call bells alarming for longer periods of time as staff were not able to respond to them promptly.

Refer to WN #8, finding #1, for details.

(F) During interviews with Inspector #625, the home's staff identified that the provision of between meal beverages and snacks was not being completed. Numerous staff identified the workload, including working with less than the full PSW staffing complement, as the reason why the beverages and snacks were not offered to all residents regularly.

Inspector #625 reviewed one of the floor's Dietary Report for January 2018 and identified that there was no documentation for 48 out of 56, or 86 per cent, of the residents to indicate that they were served, refused, on a leave of absence (LOA) or sleeping with respect to the "AM snack"/morning beverage pass. The report also identified all of the residents on that floor had ten or less documented entries out of the 31 days in January, or less than 35 per cent, of their afternoon beverage and snack entries documented.

Refer to WN #7, finding #1, for details.

(G) During interviews with Inspector #625, the home's staff identified that documentation of the provision of care provided as per the plan of care did not occur. The staff attributed working with less than the full PSW staff complement as the reason why documentation of the care provided was not completed as required.

A review of various residents' health care records by the Inspector identified the failure of staff to document the care provided to residents.

Refer to WN #1, findings #7, #8 and #9, for details.

(H) Inspector #625 reviewed documents related to a written complaint and a CIS report regarding the neglect of resident #068. The documents identified that the home had experienced staffing at less than the full PSW complement at the time of the incident, and that the staffing constraints had impacted the provision of care to the resident at that time.

During an interview with the home's Administrator, they acknowledged that staffing level deficiencies had impacted the care provided to resident #068 that shift.

Refer to WN #3, finding #1, for details.

(I) Inspector #577 reviewed documents related to a complaint to the Director and multiple CIS reports concerning incidents of responsive behaviours between resident #001 and other residents. The documents identified the resident had been ordered a level of staffing in the fall of 2017, as an intervention to manage the behaviours. The documents also identified that the ordered staffing level was not provided to the resident at the time of each incident and that, in January 2018, there was no ordered staffing level coverage for 98 per cent of the shifts.

During interviews with Inspector #577, the DOC and Administrator stated that the ordered staffing level should have been in place for the resident but that it was not provided consistently due to staffing shortages.

Refer to WN #3, finding #2, for details.

(J) Inspector #625 reviewed a staff complement document provided by Staffing Coordinator #109 that identified, when fully staffed, seven PSWs worked from 0700 to 1100 hrs and six PSWs from 1100 to 1500 hrs, on each floor on the day shift. The document also identified that six PSWs worked from 1500 to 2300 hrs on the evening shift per floor, and three PSWs worked from 2300 to 0700 hrs on the night shift for the entire home.

The document detailed the home's PSW staffing deficiencies for January 2018. The Inspector noted that the home had been working with less than the full PSW staff complement on 84 per cent of the day shifts and 87 per cent of the evening shifts in January. The document further identified that one of the floors operated with less than the full PSW complement for 23 day shifts in January, or 74 per cent of the day shifts in January; and 21 evening shifts in January, or 68 per cent of the evening shifts in January. It also identified that the other floor operated with less than the full PSW complement for 16 day shifts in January, or 52 per cent of the day shifts in January; and 20 evening shifts in January, or 65 per cent of the evening shifts in January.

During interviews with PSWs #104, #106, #108, #114, #130, #131, #134 and #135,

they identified numerous deficiencies in the home's ability to provide personal support services to residents in the home. The PSWs interviewed worked throughout the home, on various shifts, and identified staffing challenges, specifically working with less than the full complement of PSW staff, as the reason for the home's inability to provide the required services.

During an interview with the home's Staffing Coordinator #109, they stated that the home struggled with staffing, including PSW staffing, due to empty rotations (temporary and permanent), sick calls, staff injuries resulting in employees requiring work modifications and staff not picking up shifts/over time shifts.

During interviews with the home's Administrator, they stated that the home could not expect the staff to do any more than basic personal care, which they struggled to get done, when staff were working short. They acknowledged the staffing deficiencies detailed in the staffing complement document, that the home was operating with significant staffing shortages and challenges and that the PSW staffing deficiencies had negatively affected resident care.

The decision to issue a compliance order was based on the severity which identified the potential for actual harm to occur, and although the home did not have a compliance history related to this specific area of the legislation, the scope was widespread and represented a pervasive deficiency within the home. (625)

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

Jun 30, 2018(A2)

Pursuant to / Aux termes de :

LTCHA, 2007, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.

The licensee shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff.

The licensee shall specifically:
- Review the home's zero tolerance of abuse and neglect policies and identify how the home's staff failed to comply with the policies;
- Rectify any deviations from the policy that can be corrected;
- Provide training to the staff involved in the incidents and follow-up investigation regarding the requirement to ensure residents are not abused by anyone and not neglected by the licensee or staff, and their responsibilities as outlined in the zero tolerance of abuse and neglect policies; and
- Maintain records of the actions taken with respect to the above.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were protected from abuse by anyone and neglect by the licensee or staff.

A complaint was received by the Director in the winter of 2018, concerning residents with responsive behaviours in the home that were required to have a particular staffing level and were not being provided with the staffing required. The complaint indicated that resident #001 was exhibiting responsive behaviours, some of which involved other residents.

Ontario Regulation 79/10, s. 2 (1), includes in the definition of physical abuse "the use of physical force by a resident that causes physical injury to another resident".

Inspector #577 reviewed multiple CIS reports submitted to the Director over several months in 2017 and 2018. The reports detailed abuse between resident #001 and several other residents. A report dated the fall of 2017, identified that ordered staffing levels were provided when staff were available.

A review of physician orders for resident #001 identified an order for a level of staffing written in the fall of 2017, to assist with monitoring and minimizing resident #001's responsive behaviours.

During a review of resident #001's schedule of the ordered level of staffing coverage, Inspector #577 identified a lack of the staffing coverage provided during 34 per cent of the shifts in one month in 2017; 69 per cent of the shifts in another month in 2017; and 99 per cent of the shifts in a month in 2018.

A review of resident #001's health care record identified that resident #001 had multiple incidents of responsive behaviours towards other residents that were documented in the electronic progress notes, over a several months in 2017 and 2018 . At the time of the responsive behaviours that occurred between residents on multiple dates in the fall of 2017 to the winter of 2018, the ordered staffing coverage was not utilized.

A review of resident #001's care plan effective at the time of the responsive behaviours from the fall of 2017 to the winter of 2018, identified that staff were to utilize specific interventions to address several responsive behaviours. The care plan indicated that staff were to follow the suggestion from Behavioural Supports Ontario (BSO) and listed one specific intervention.

Inspector #577 found a list of recommended strategies documented by BSO in a Kardex binder, which included triggers, behaviours and strategies that were developed in the fall of 2017. Inspector #577 noted that these were not listed in the resident's care plan. The document identified specific responsive behaviours, specific triggers, and recommended many strategies that were not in the resident's care plan.

During an interview with PSW #116, they reported that resident #001 had exhibited responsive behaviours towards others. They reported that resident #001 would exhibit a specific behaviour and identified two specific triggers.

During an interview with PSW #117, they reported that resident #001 had exhibited responsive behaviours towards others, and identified a specific trigger. They reported that the resident exhibited a specific behaviour and an intervention the staff implemented to address the behaviour.

During an interview with PSW #138 from the BSO Mobile Outreach Team, they reported that resident #001 exhibited responsive behaviours towards others and identified several behaviours, including some that were harmful to others. They further reported that the identified triggers, behaviours and strategies should have been incorporated and written into the resident's care plan.

During an interview with RN #103 they reported that the recommended strategies, including the identified triggers, provided by BSO Psychogeriatric Resource Consultant should have been transcribed into resident #001's care plan.

Inspector #577 conducted interviews with the DOC and Administrator who reviewed resident #001's progress notes related to responsive behaviours and the schedule of the ordered staffing level. The DOC and Administrator acknowledged that the ordered staffing level was ordered in the fall of 2017, and it was the expectation that the supervision would have always been in place, but was not provided consistently due to staffing issues.They further confirmed that the triggers, behaviours and strategies documented by BSO and the nursing intervention of the ordered staffing level were not incorporated into resident #001's care plan. In addition, they confirmed that the ordered staffing level was not provided on multiple dates in the fall of 2017 and winter of 2018, when resident #001 exhibited responsive behaviours towards other residents.

Refer to WN #1, finding #2, and WN #6, finding #1 for details. (625)

2. Ontario Regulation 79/10, s. 5, defines neglect as the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that jeopardizes the health, safety or well-being of one or more residents.

Inspector #625 reviewed a CIS report received by the Director identifying that resident #068 was neglected on a date in the winter of 2018. The report detailed that

the resident had been using a mobility aid that had become soiled with a body fluid, and that interventions the resident required related to continence had not been completed all day. Actions to prevent recurrence listed included reinforcement of one intervention and the responsibility of staff to follow the care plan, ongoing efforts to ensure a full staffing complement, including significant recruitment and retention activities, and "meted out discipline as appropriate".

A review of resident #068's care plan that was in place at the time of the incident identified that the resident experienced a medical condition, staff were to complete an intervention related to continence at specific frequencies and were to complete another related intervention as needed.

Emails dated the winter of 2018, from resident #068's family member #136 to the home's Administrator and DOC, identified that resident #068 had not had either of the interventions related to continence completed for an extended period of time until a family member visited the home and requested it during the evening; and the resident's mobility aid was soiled with a body fluid. The emails also identified that resident #068 had not had the continence related interventions completed on a few other recent occasions which the family member spoke to the PSW staff about and were told that the resident had not had an intervention completed due to staff shortages. The second email identified that the family member had attended the home on a particular date in the winter of 2018, and found the resident using their mobility aid which "smelled very strongly of [the body fluid]". When the mobility aid was washed by the family member and later by another PSW the email indicated the "water immediately turned [colour] and smelled of [the body fluid]" and "a lot of [the body fluid] poured out". The email from family member #136 also stated "I am concerned that this issue is not really resolved from a staff role, education, awareness or understanding of what personal dignity means".

Documented interviews with PSW #110 and the home's management identified that the PSW stated resident #068 was to receive an intervention related to continence at a specific frequency, received the intervention during the morning on date in the winter of 2018, and refused one intervention without another intervention being completed in the afternoon. The notes identified that PSW #110 informed the next shift that the resident had refused one intervention that afternoon.

Documented interviews with PSW #116 and the home's management identified that the PSW was aware that the resident had not had the intervention completed that

afternoon, they did not complete either of the interventions at the beginning of the shift, and they did not complete either intervention until the resident's family member requested one intervention be completed, at which time the resident was soiled. The notes also identified that the PSW acknowledged that they should have completed one intervention at the frequency specified in the resident's care plan and that "[PSW #116] received a verbal discipline for not following care plan of [completing a specific intervention related to continence at a specific frequency] as indicated".

Notes from interviews with RNs #113 and #102 and the home's management identified that RN #113 stated they had informed RN #102 of the need for resident #068's mobility aid to be washed but RN #102 did not recall being informed of this.

Documented interview notes with PSW #137 identified that the PSW found resident #068's mobility aid in an equipment washer room and it was not wet but stated "I thought it smelled...", and they were not sure if the mobility aid had been washed but they needed it so they used it.

A review of a "Resolution of Complaints" document provided to the Inspector by the home's Administrator, identified that, in the winter of 2018, neglect occurred as resident #068 did not have either of two continence related interventions completed over a 5.5 hour period; during the night following the neglect as the resident's mobility aid was not washed or was not washed properly; and on the particular date immediate discipline and guidance was provided to the individual PSW who did not implement a continence related intervention over a four hour period, until resident #068's family raised a concern. The document had a hand written notation "Encourage staff not to complain about being short".

A review of a staffing complement document provided by Staffing Coordinator #109 identified, with respect to PSW staffing on the particular day in the winter of 2018, the home was short one PSW on one floor from 0700 hrs to 1100 hrs and one PSW from 1500 hrs to 2300 hrs; and one PSW on another floor from 0700 hrs to 1100 hrs and two PSWs from 1500 hrs to 2300 hrs. The document indicated that the home was short a total of 3 PSWs [out of 12] on the shift when the incident occurred.

A review of the home's resident census list identified that resident #068 resided on a particular floor, which had worked with less than the full PSW staff complement from 0700 to 1100 hrs and 1500 to 2300 hrs on the date of the incident.

During an interview with family member #136, they confirmed the details provided in the email they had sent to the home's management in the winter of 2018. The family member further stated that, with respect to the incident that occurred in the winter of 2018, the resident's mobility aid had been soiled with a body fluid and it looked like the resident had not had a continence related intervention completed all day. The family member stated that, the day after the incident, the mobility aid had not been washed, reeked of the body fluid and was still damp. The family member also identified that, on the date of the incident they had stated to a PSW "It looks like neglect" and on the next day, they repeatedly used the word "neglect" when speaking to the home's Administrator and DOC. The family member identified that the PSW involved in the incident had informed the family member that they were "short staffed" at the time of the incident and that it was evident to the family member when the home was short staffed.

The Inspector viewed a video provided by family member #136, of the resident's moblity at the time of the incident. The video showed puddles of liquid on a portion of the mobility aid. The video identified the liquid underneath the seat cushion as a specific body fluid and that another part of the mobility aid was also saturated with the body fluid.

During an interview with the home's Administrator, they acknowledged that resident #068 probably last had a continence related intervention completed before lunch, but that staff should have completed the continence related intervention if the resident had refused another continence related intervention earlier in the day, that the home did not have a full PSW staff complement on the date of the neglect, that the PSW involved stated that they couldn't possibly get it all done, and that they were sure staffing affected the care provided to the resident that shift. The Administrator also acknowledged that they could not guarantee that the resident's mobility aid had been washed after the incident, but it was washed the next day when the home suspected it had not been washed due to communication problems.

During RQI #2016_333577_0012, commencing May 27, 2016, a compliance order (CO) and a Director Referral (DR) were issued. During RQI #2015_333577_0016, commencing on October 5, 2016, a CO was issued.

The decision to issue a compliance order was based on the severity which identified the potential for actual harm to occur, and although the scope was isolated, the home has a history of non-compliance specific to this area of the legislation, including a

previous Director Referral. (625)

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

May 31, 2018(A1)

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. 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) of Ontario Regulation 79/10.

The licensee shall ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

The licensee is specifically ordered to:
- Conduct an audit of all of the residents in the home requiring weekly wound assessments by registered nursing staff;
- Complete a weekly wound assessment of the residents' wounds, including residents #027, #029 and #033' s altered skin integrity, if required;
- Establish an auditing routine to ensure that weekly wound assessments are being completed as required;
- Identify the factors and/or causes resulting in a lack of weekly wound assessment completion and address them; and
- Maintain records of the actions taken with respect to the above items.

Grounds / Motifs :

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

Resident #033 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #033's RAI-MDS assessment dated in the fall of 2017, which identified that the resident had multiple areas of altered skin integrity.

The Inspector reviewed the home's program "Skin and Wound Care Program Long-Term Care" dated July 2016. The program identified that staff were to complete the Wound Tracker documentation after a dressing change and weekly documentation was to include the size (circumference and depth) of the wound, discharge from the wound, appearance, progression, pain, nutrition and equipment being used. Appendix A: Skin and Wound Care – Overview identified that, with pressure ulcers, weekly assessment and evaluation (with documentation in the resident chart, RAI,

care plan) were required.

Inspector reviewed the document titled, "Wound Documentation Days" that indicated staff were required to document any wounds that the residents had on the days specified in the Wound Tracker and the documentation was to include the wound type, measurements and current treatment.

Inspector reviewed the document titled, "Wound Tracker" that identified all wounds, including pressure ulcers, were to be documented and monitored in the "Wound Tracker".

A review of the resident's current health care record included:
- resident #033's current "Wound Assessment Tool" which identified wound characteristics staff were required to assess and document on the tool, with each treatment and weekly. The tool indicated resident #033's treatment was to be completed at specific frequencies, and contained multiple entries in the winter of 2018. Neither of the entries contained any characteristics required to be assessed and documented with each treatment or weekly, as specified on the tool; and
- the resident's electronic progress notes which identified the most recent progress note related to the altered skin integrity was dated in the fall of 2017. The note did not contain an assessment of the altered skin integrity.

During interviews with RAI Coordinator #122, they stated that the home had used the "Wound Tracker" electronic assessment tool at one time as listed in the home's Skin and Wound Care Program but had stopped using it and adopted electronic charting of wound assessments in progress notes by registered staff. They acknowledged that #033's most recent "weekly" wound assessment had been completed in the fall of 2017, approximately three months earlier.

During an interview with Inspector #625, RN #103 stated that staff were supposed to complete wound assessments in the "Wound Tracker" but had not been doing so, and had not been completing electronic progress notes for wound assessments, as they did not have enough time in the shift to do so. The RN stated that staff generally did not have time to complete wound assessments, chart them, or adhere to a daily schedule for wound assessment charting. (625)

2. Resident #027 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #027's RAI-MDS assessment dated in the fall of 2017, which identified that the resident had multiple areas of altered skin integrity.

A review of the resident's current health care record included:
- a "Wound Assessment Tool", that identified that the resident required a treatment to a part of their body to be completed at a specific frequency. The document did not list the resident's most recent treatment order. The tool listed wound characteristics staff were to document at specified frequencies. Of the multiple documented entries listed between 12 days in the winter of 2018, none contained the majority of characteristics required to be assessed and documented weekly. The last documented entry was dated in the winter of 2018, 16 days prior.
- a review of the resident's electronic progress notes identified the most recent progress note related to the altered skin integrity was dated in the fall of 2017. The note did not contain an assessment of the altered skin integrity.

During an interview with RAI Coordinator #122, they acknowledged that resident #027's most recent "weekly" wound assessment had been completed some time in the fall of 2017, approximately two to three months earlier. (625)

3. Resident #029 was identified as being at risk for altered skin integrity and having altered skin integrity, according to a RAI-MDS assessment.

Inspector #625 reviewed resident #029's RAI-MDS assessment dated in the fall of 2017, which identified that the resident had altered skin integrity.

During an interview with resident #029, they stated to the Inspector that they currently had altered skin integrity.

A review of the resident's current health care record included:
- a "Wound Assessment Tool", that identified that a treatment to a particular part of the resident's body was to be completed at specific frequencies. The tool listed wound characteristics staff were to document at specified frequencies. Of the

multiple documented treatments between two dates, 16 days apart, in the winter of 2018, none of the entries contained all of the required information to be recorded with each treatment and none contained the majority of characteristics required to be assessed and documented weekly. The last two documented treatments were dated seven days apart, in the winter of 2018, which did not indicate the treatment had been completed at the frequency specified on the tool. The last date the tool listed a complete assessment, including the size and characteristics of the altered skin integrity details was on a date in the fall of 2017; and
- the resident's electronic progress notes, that identified the most recent progress note related to the altered skin integrity was dated the fall of 2017, but it did not contain an assessment of the altered skin integrity.

During interviews with RAI Coordinator #122, they acknowledged resident #029's most recent complete "weekly" wound assessment recorded on the Wound Assessment Tool was dated in the fall of 2017, approximately four months earlier, and the most recent "weekly" wound assessment completed in the Wound Tracker was dated in the fall of 2017, approximately three months earlier. The RAI Coordinator acknowledged that there was no documentation in the resident's electronic progress notes on the wound since a third date in the fall of 2017, approximately three months earlier, and the last documentation on the "Wound Assessment Tool" to indicate the dressing had been changed was dated in the winter of 2018, or six days earlier.

During RQI #2017_463616_0007, commencing on May 15, 2017, a VPC was issued specific to this area of the legislation.

The decision to issue this compliance order was based on the severity which indicated the potential for actual harm to occur, and the scope, which identified a widespread pattern of occurrence within the home. In addition, the home has a history of non-compliance specific to this area of the legislation. (625)

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

Jun 15, 2018(A2)

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 : 006

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

Linked to Existing Order / Lien vers ordre existant: 2017_463616_0007, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, 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

(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).

Order / Ordre :

The licensee must be compliant with s. 129 (1) (a) (ii) of Ontario Regulation 79/10.

The licensee shall ensure that drugs are stored in an area or a medication cart that is secure and locked.

The licensee shall specifically:
- Ensure treatment carts containing medicated topical treatments are locked when not in use or supervised (ensuring the keys are not left in the carts);
- Ensure any care carts which contain medicated topical treatments are locked when not in use or supervised;
- Ensure the care carts contain functional locked areas and can be repaired or replaced promptly when required;
- Conduct an audit of medicated topical treatments kept unsecured at residents' bedsides, including at resident #010's bedside. Ensure the medicated topical treatments, or any other drugs found at the bedside, are stored and used as per the requirements identified in O. Reg. 79/10, s. 129 and s. 131 (1), (5) (6) and (7);
- Establish a routine auditing schedule to address drugs stored in treatment carts, care carts and at the bedside, to ensure compliance with applicable legislation; and
- Maintain a record of the actions taken to address the above items.

Grounds / Motifs :

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

Compliance order #001 was issued from inspection #2017_463616_0007 pursuant to r. 129 (1) (a) (ii). The licensee was ordered to ensure that drugs were stored in an area or a medication cart that was secure and locked. The compliance due date was August 16, 2017.

On two dates in the winter of 2018, Inspector #625 observed a medicated topical treatment cream in resident #010's room. On the second date the treatment cream was observed, the resident was not in their room and no staff were present when the cream was observed.

On a date in the winter of 2018, from 0900 hrs to 0955 hrs, Inspector #625 toured the home and observed medicated topical treatments that were located in unlocked care cart lock boxes, in an unlocked treatment cart, or sitting directly on care carts. Inspector #625 observed medicated topical treatments not secured and locked, while not in use or supervised by staff.

On one floor, in four unlocked care cart lock boxes, topical treatment gels, creams, pastes and/or shampoos were observed for residents #027, #039, #040, #041, #042, #043, #044, #045, #046, #047, #048, #049 and #050.

On another floor, in one treatment cart and in three unlocked care cart lock boxes, topical treatment gels, creams, pastes and/or shampoos were observed for residents #001, #005, #008, #051, #013, #036, #037, #035, #052, #053, #054 and #056.

During an interview with Inspector #625, PSW #104 acknowledged that they had not locked the lock box on their care cart while it was unattended and that medicated topical treatments were in the unlocked box. The PSW stated that the box should have been locked.

During an interview with PSW #105 they acknowledged that they had not locked the lock box on their care cart while it was unattended and that medicated topical treatments were in the unlocked box. The PSW stated that the box should have been locked.

During an interview with PSW #106 they stated to the Inspector that they had not locked their care cart lock box as the lock was broken and the key could not be removed when the lock was in the locked position. The PSW demonstrated this to the Inspector and stated that they were aware that the box containing topical medicated treatments should be locked.

During an interview with RN #102, they acknowledged that the treatment cart on one of the floors was not locked and contained medicated topical treatments for residents. The RN stated that registered nursing staff should lock the treatment cart when it was not in use.

During an interview with the DOC, they acknowledged that two unsupervised care cart lock boxes on one of the floors were not locked but should have been as they contained medicated topical treatments. The DOC stated that they were aware of a

lock box which required repair and could not be locked at that time. The DOC also acknowledged that the treatment cart on one of the floors contained medicated topical treatments and should have been locked. The DOC and Inspector observed the unsupervised treatment cart to have the key in the lock which was used to open the cart and access the medicated treatment creams inside. The DOC then attended resident #010's room with the Inspector and acknowledged unlocked and unsecured medicated topical treatment cream present.

During an interview with the Administrator, they stated to Inspector #625 that medicated topical treatments should be locked in care cart lock boxes when not in use and that staff were aware of this requirement. The Administrator acknowledged that a lock box currently in use in the home required repair and could not be locked until it was repaired or replaced.

During RQI #2017_463616_0007, commencing on May 15, 2017, a CO was issued specific to this area of the legislation. During RQI # 2016_333577_0012, commencing on May 27, 2016, and RQI #2015_333577_0016, commencing on October 5, 2015, VPCs were issued specific to this area of the legislation.

The decision to issue a compliance order was based on the severity which was identified as the potential for actual harm to occur, and the scope, which demonstrated a pattern of occurrence. The home has a history of non-compliance with this area of the legislation and this is the second consecutive issuance of an order specific to this area of the legislation. (625)

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

May 31, 2018(A1)

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 : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s. 54. (b) of Ontario Regulation 79/10.

The licensee shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

The licensee shall specifically:
- Identify the residents in the home, including residents #001, #002, #004 and #005, who exhibit particular responsive behaviours. Include residents who have engaged, or could likely engage, in altercations and potentially harmful interactions between and among other residents;
- Determine which residents have been provided with recommendations or suggestions for interventions from consultants related to this behaviour;
- Incorporate appropriate interventions into the residents' plans of care, ensuring that the residents' care plan interventions are clear to those staff who provide direct care to the residents;
- Ensure that all of the identified residents' plans of care, including care plans, contain identified and implemented interventions specific to minimizing the risk of altercations and potentially harmful interactions between and among residents; and
- Maintain records of the actions taken with respect to the above.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including identifying and implementing interventions.

Inspector #577 reviewed CIS reports submitted to the Director on dates:
- in the fall of 2017, which identified abuse between residents #001 and #002. The report indicated that resident #001 exhibited responsive behaviours involving resident #002. As per the report, resident #002 sustained an injury. The report further indicated that several days prior, resident #001 exhibited a responsive behaviour involving resident #002, where resident #002 sustained an injury.

- in the fall of 2017, which identified abuse between residents #001 and #003. The report indicated that resident #001 exhibited a responsive behaviour involving resident #003. As per the report, resident #003 sustained an injury.

- in the fall of 2017, which identified an altercation between residents #001 and #002.

- in the fall of 2017, which identified resident #001 exhibited responsive behaviours involving resident #004. The report further indicated that resident #004 exhibited a behaviour involving resident #001, resulting in resident #004 sustaining injuries.

- in the fall of 2017, which identified an altercation between residents #001 and #005. The report indicated that resident #001 exhibited a responsive behaviour involving resident #005, which escalated into an altercation, where resident #005 then exhibited behaviours involving resident #001.

- in the winter of 2018, which identified an altercation between residents #001 and #002. The report indicated that residents #001 and #002 exhibited responsive behaviours involving each other.

A review of resident #001's health care record identified that the resident had multiple incidents of responsive behaviours towards other residents, which were documented in the electronic progress notes over several months in the fall of 2017 to the winter of 2018. The progress notes indicated the incidents occurred on multiple dates in the fall of 2017 and the winter of 2018, and the notes related to the CIS reports were consistent with the information in the reports.

A review of resident #001’s care plan effective at the time of the responsive behaviours from the fall of 2017 to the winter of 2018, identified under the nursing focus Behaviours, staff were to utilize multiple interventions. The care plan intervention indicated that staff were to follow a suggestion from Behavioural Supports Ontario (BSO).

Inspector #577 found a list of recommended strategies documented by BSO in a Kardex binder, which included triggers, behaviours and strategies that were developed in the fall of 2017. Inspector #577 noted that these were not listed in the resident's care plan. The recommendations identified specific behaviours exhibited towards others and listed triggers for the behaviours. There were many recommended strategies listed that were not listed in the resident's care plan.

A review of the physician's orders for resident #001 indicated an ordered level of staffing written in the fall of 2017, the same date the oldest CIS report reviewed was dated, to assist with monitoring and minimizing resident #001's responsive behaviours.

A review of resident #001's schedule of the ordered staffing level coverage for a month in 2017, identified there was no ordered staffing level coverage for 31 out of 90 shifts, or 34 per cent of the shifts; in addition, five out of 90 shifts, or 6 per cent, did not have the ordered staffing level coverage for the entire shift. A review of the ordered staffing level coverage for another month in 2017, identified there was no ordered staffing level coverage for 64 out of 93 shifts, or 69 per cent of the shifts; in addition, 40 out of 93 shifts or, 43 per cent of the shifts, did not have the ordered staffing level coverage for the entire shift. A review of staffing level coverage for a month in 2018 identified there was no ordered staffing level coverage for 90 out of 91 shifts, or 99 per cent of the shifts.

A further record review of the progress notes indicated that at the time of all of the responsive behaviours between residents on multiple dates in the fall of 2017 to the winter of 2018, the ordered staffing level was not utilized.

During an interview with PSW #116, they reported that resident #001 had exhibited responsive behaviours towards others. They reported a specific behaviour and trigger.

During an interview with PSW #117, they reported that resident #001 had exhibited responsive behaviours towards others, and identified a trigger. They reported specific activities resident #001 engaged in related to safety.

During an interview with PSW #138 from the BSO Mobile Outreach Team, they reported that resident #001 exhibited responsive behaviours towards others and identified multiple behaviours the resident exhibited. They further reported that the identified triggers, behaviours and strategies should have been incorporated and written into the resident's care plan.

During an interview with RN #103 they reported that the recommended strategies, including the identified triggers, provided by BSO Psychogeriatric Resource Consultant should have been transcribed into resident #001's care plan.

Inspector #577 conducted interviews with the DOC and Administrator, who reviewed resident #001's progress notes related to responsive behaviours and the schedule of the ordered staffing level. They reported that the staffing level was ordered in the fall of 2017, and it was the expectation that the supervision would have always been in place but was not provided consistently due to staffing issues. They further confirmed that the triggers, behaviours and strategies documented by BSO and the nursing intervention of the ordered staffing level were not incorporated into resident #001's care plan. In addition, they confirmed that the ordered staffing level was not provided on multiple dates in the fall of 2017 to the winter of 2018, when there were altercations between resident #001 and other residents.

The decision to issue a compliance order was based on the severity which identified actual harm had occurred and, although the home does not have a history of non-compliance specific to this area of the legislation, the scope demonstrated a pattern of occurrence. (625)

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

May 31, 2018(A1)

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 : 008

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

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) (b) and (c) of Ontario Regulation 79/10.

The licensee shall ensure that each resident is offered a minimum of a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, and a snack in the afternoon and evening.

The licensee shall specifically:
- Develop a schedule and assign specific staff to offer each resident in the home a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner, and a snack in the afternoon and evening;
- Consult with the staff prior to implementing the schedule to determine if the schedule can be reasonably foreseen to be implemented successfully and consistently;
- Modify the schedule as required, based on staff and resident feedback;
- Include a contingency plan, to be implemented if specific staff assigned to complete the task are not able to do so;
- Develop and implement a reporting structure, where the provision of beverages and snacks are supervised to ensure completion;
- Develop and implement an auditing routine, taking into consideration each between-meal beverage and snack offering, to ensure that each resident in the home has been offered a beverage or snack, as required; and
- Maintain records of the actions taken with respect to the above.

Grounds / Motifs :

1. The licensee has failed to ensure that each resident was offered a minimum of a between meal beverage in the morning and afternoon and a beverage in the evening after dinner, and a snack in the afternoon and evening.

Complaints were received by the Director related to the impact that staffing shortages had on the provision of nursing and personal care services to residents.

During interviews with Inspector #625, PSWs #104, #106, #108, #114, #130, #131, #134 and #135 stated that beverages and snacks were not given out to residents when the staff were working short. The PSWs interviewed worked on both the second and third floors.

During an interview with PSW #105, they stated that beverages were never given to residents in the mornings, in between breakfast and lunch. The also stated that in the evenings, "99 per cent" of the time, the beverages and snacks were not given out but they would try to provide beverages and snacks to diabetic residents.

During an interview with PSW #135, they stated that when they were working short they did not give out snacks, but certain people, such as diabetic residents and those who requested a beverage or snack, were given beverages and snacks in between meals. The PSW stated that, on a date in the winter of 2018, morning beverages were not provided and that they had not observed the beverage cart go around in a long time. The PSW also stated that beverages and snacks were not offered to residents during the afternoon of the previously mentioned date in the winter of 2018, due to a staff shortage.

PSW #123 identified to the Inspector that, on the evening of a date in the winter of 2018, one floor was only able to offer beverages and snacks to diabetic residents and those residents who specifically requested them, as the floor was working with four PSWs, instead of the required complement of six.

During interviews with Inspector #625, resident #037 stated that, generally, beverages and snacks were not offered to them in the afternoons and evenings; and resident #010 stated staff did not go around to offer beverages, they were never offered a snack but they could go and ask if they wanted something.

During an interview with Inspector #621, resident #033 stated that staff did not offer beverages to residents in between meals, and they hadn't been offered a snack in the afternoon or evening for the last seven days.

Inspector #625 reviewed the Dietary Report for a month in the winter of 2018 for one of the floors in the home, with respect to the "AM snack"/morning beverage pass, and identified that there was no documentation for 48 out of 56, or 86 per cent, of the residents to indicate that they were served, refused, on a leave of absence (LOA) or sleeping with respect to the morning beverage pass. Of the eight residents who had documentation related to the provision of the morning beverage, all eight had only one entry in that month, including the documentation of refusals and LOAs.

The Inspector reviewed the previously mentioned Dietary Report, with respect to the

"PM snack" which included afternoon beverages and snacks for 56 residents, and identified that:
- three residents had no documentation to indicate they were served, refused, on a LOA or sleeping on any date during that month;
- 14 had one documented entry;
- 14 had two documented entries;
- eight had three documented entries;
- seven had four documented entries;
- three had five documented entries; and
- seven had six to ten documented entries.

In total, 100 per cent of residents on that floor had ten or less documented entries out of the entire month in 2018, or less than 35 per cent, of their afternoon beverage or snack entries documented.

During an interview with RPN #122, they reviewed the Dietary Reports previously reviewed by the Inspector, and stated that resident #030 did not have "AM snack" listed which meant they were never recorded as being given or refusing a beverage in between breakfast and lunch; resident #060 had only one item listed for "AM snack" which meant they were never recorded as ingesting more than one morning beverage that month; resident #027 did not have "AM snack" or "PM snack" listed which meant they were never recorded as being given or refusing a morning or afternoon beverage or snack that month.

During a phone interview with RN #102, they reviewed the Dietary Reports for a specific floor during a month in the winter of 2018 and acknowledged that only eight residents had any documentation pertaining to the provision of the "AM snack"/morning beverage.

The decision to issue a compliance order was based on the severity which indicated the potential for actual harm to occur and, although the home does not have a compliance history specific to this area of the legislation, the scope was widespread. (625)

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

Jun 30, 2018(A2)

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

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

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

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

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

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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)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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 18 day of May 2018 (A2)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by STEPHANIE DONI - (A2)

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

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Service Area Office / Bureau régional de services : Sudbury