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 sous *la Loi de 2007 sur les foyers de soins de longue durée*

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 24, 2018	2018_580568_0014 (A1)	003353-18, 003355-18, 003356-18, 003357-18, 003364-18, 003640-18, 003764-18, 003787-18, 004223-18, 005058-18, 006297-18, 006426-18, 008608-18, 010694-18, 011889-18, 013143-18, 015287-18, 016055-18, 018525-18, 018571-18, 018738-18, 018740-18, 019716-18, 020199-18, 023459-18	Follow up

Licensee/Titulaire de permis

Corporation of the County of Bruce
30 Park Street WALKERTON ON N0G 2V0

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

Brucelea Haven Long Term Care Home - Corporation of the County of Bruce
41 McGivern Street West P.O. Box 1600 WALKERTON ON N0G 2V0

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

Amended by MARIA MCGILL (728) - (A1)

Ontario

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Amended Inspection Summary/Résumé de l'inspection modifié

Extension to compliance due dates.

Issued on this 24th day of December, 2018 (A1)

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

Original report signed by the inspector.

Ontario

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

Amended by MARIA MCGILL (728) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): August 28, 29, 30, 31, 2018; September 4, 5, 6, 7, 10, 11, 12, 13, 14, 16, 17, 18, 19, 20, 21, 24, 25, 2018

Inspector #729 also participated in the inspection.

The following intakes were completed in this Follow-up Inspection:

Log #003640-18, Critical Incident System (CIS) #M507-000006-18; log #003764, CIS #M507-000008-18; log #003787-18, CIS #M507-000009-18; log #004223-18, CIS #M507-000007-18; log #006297-18, CIS #M507-000011-18; log #008608-18, CIS #M507-000014-18; log #011889-18, CIS #M507-000021-18; log #018525-18, CIS #M507-000030-18; log #015287-18, CIS #M507-000027-18 related to improper care or neglect of residents;

Log #005058-18, CIS #M507-000010-18; log #006426-18, CIS #M507-000012-18; log #023459-18, CIS #M507-000017-18,; log #010694-18, CIS #M507-000018-18; log #018571-18, CIS #M507-000029-18; log #013143-18, CIS #M507-000022-18 related to resident abuse.

Please note: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 6 plan of care; O. Reg 79/10, s. 50. (2) (a) (ii), s. 50 (2) (b) (iv) - skin and wound assessments, and s. 31 (3) sufficient staffing, identified in a concurrent inspection #2017_580568_0016 (log #020637-18, CISM507-000031-18 and log #028934-17, IL-54586-LO) were issued in this report.

Please note: A Written Notification and Compliance order related to LTCHA, 2007, c.8, s. 6. (7). s. 6. (10 (b) plan of care; O Reg. 79/10 s. 50. (2) (a) (i) (ii) skin and wound assessments, and s. 31 (3) sufficient staffing, identified in a concurrent inspection #2017_580568_0015 (log #001237-18, CIS #M507-000001-18; log #028809-17, CIS #M507-000027-17; log #003569-18, CIS #M507-000005-18; log #028619-17, CIS #M507-000025-17; log #028615-17, CIS #M507-000024-17) were issued in this report.

During the course of the inspection, the inspector(s) spoke with the Director of health Services, Administrator, Director of Care, Administrative Assistant, RAI Coordinator, Dietary manager, Ward Clerk, Recreation & Leisure Program Volunteer Coordinator, Environmental Services Supervisor, County of Bruce Human Resource Supervisor, Recreation & Leisure Manager, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Housekeepers, Recreation & Leisure Aides, Dietary Aides, Ward Clerk, Maintenance staff, a physician, residents and families.

The inspectors also observed medication administration, medication storage, reviewed relevant clinical records, policies and procedures, meeting minutes, staff schedules, medication incidents; observed the provision of resident care, resident-staff interactions, and the safety of the home.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Pain
Prevention of Abuse, Neglect and Retaliation
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

8 WN(s)
1 VPC(s)
7 CO(s)
1 DR(s)
0 WAO(s)

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations; 2007, c. 8, s. 23 (1).
(b) appropriate action is taken in response to every such incident; and 2007, c. 8, s. 23 (1).
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that every alleged, suspected or witnessed incident that the licensee knows of, or that is reported is immediately investigated: (i) Abuse of a resident by anyone, ii) Neglect of a resident by the licensee or staff.

a) A written statement from a family member indicated that they spoke with the Director of Care (DOC) and informed them about a concern they had regarding an identified resident in relation to potential abuse. The family member then filed a report with the Ontario Provincial Police.

A Registered Practical Nurse (RPN) said that the identified resident alleged on more than one occasion that they may be a victim of abuse. When asked if they reported this, the RPN said they told the Administrator.

The DOC told the Inspector that it was brought to their attention by a family member of a resident that the resident may be a victim of abuse. When asked if

anyone had spoken with the resident the DOC said they could not recall. The DOC said they spoke with the Administrator about the situation of alleged abuse. When asked if they had started an investigation into the allegation, they said no.

The Administrator said they became aware of the allegations of abuse from the DOC. When asked if they had investigation notes, the Administrator said all references were in the Critical Incident System (CIS) report and they had no other investigation documentation. The Administrator said that the family member went to police about the incident and they thought the MOHLTC would see the CIS report and decide whether further investigation was warranted. When asked if they had interviewed the resident or those involved, the Administrator acknowledged they had not done this. When asked about notification of authorities the Administrator said they had not done this initially and later the family member contacted police.

b) A CIS report was submitted to the MOHLTC for an incident of alleged improper care / neglect. According to the report an email was sent to the DOC regarding several residents that were not provided continence care during the night shift.

The home's investigation record included a copy of an email sent by a RPN to the DOC. The email stated that staff had brought to the RPN's attention several residents that were not provided with continence care during the night shift. The RPN said they observed one of the residents and it was evident they had not been provided with continence care. The email identified the PSW that worked the night shift on that unit.

The DOC stated that the email referred to in the CIS report must have gotten lost in their inbox. It was not until a staff member spoke with them two weeks later about the incident that the DOC went back to look at their emails. At that point the DOC said they commenced their investigation into the incident. The DOC said that they recalled picking up a message the day after it was left regarding an incident on the identified floor but did not go to investigate further.

The licensee failed to ensure that an alleged incident of neglect of residents was immediately investigated.

c) On a specified date a resident reported to a RPN that a staff member left them unattended for a long time and was verbally abusive. The resident was not able to provide the RPN with the name of the staff, but did describe them. The DOC

called the MOHLTC after hours pager and the home submitted a CIS report.

During an interview with the RPN they shared that what they recalled the resident reported was that the staff member did not allow the resident nourishment and the staff member was rough. The RPN said they did not know who worked that shift but they immediately reported it to the DOC.

During an interview with the staff member who provided care for the resident at the time of the alleged incident they denied the allegations. The staff member shared that they provided care to for the same resident that next shift.

The DOC stated that they were aware of the allegation of abuse on the day it was reported as they called the MOHLTC after hours pager that day. The DOC said they started the investigation two days later as they were off work.

d) The home submitted a CIS report that stated the DOC received an email from a RPN which stated that a resident brought a concern forward that the staff that did their care was rough with them. The RPN noted in the email that the resident expressed concerns about a specific PSW.

Review of the home's investigation notes showed that the RPN sent the email to the DOC regarding this concern on a specified date. The CIS report was submitted three days later. The resident and the PSW were interviewed four days later by the DOC.

The DOC acknowledged that their investigation did not start until four days after the incident in question.

2. The licensee has failed to ensure that the results of the abuse or neglect investigation were reported to the Director.

In making a report to the director under subsection 23 (2) of the Act, the licensee shall include all material that is provided for in the regulations specifically but not limited to O.Reg. 79/10, s. 104 (1) (2) (3) that states the licensee shall include the following material in writing:

(1) A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.

(2) A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident.
(3) Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decision maker of any resident involved int he incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
(4) Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long term actions planned to correct the situation and prevent recurrence.
(5) The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

a) A CIS report was submitted to the MOHLTC which stated that an email was sent to the DOC regarding several residents that were not provided continence care. Three residents were identified in the CIS report. The staff who discovered the incident were identified but the only mention of the staff member involved was their first and last initials.

The DOC said they became aware of two other residents who were involved in the incident during their investigation but had not updated the CIS report with their names. In addition, the DOC stated that they had not notified those residents' substitute decision makers (SDMs) of the alleged incident of neglect and they had not pursued an investigation of those residents. With respect to the full names of staff involved in the incident not being included on the CIS report, the DOC was unaware that this was required.

The licensee failed to ensure that the names of all residents, notification of all SDMs and full names of all staff involved in the alleged incident of neglect / incompetent care were reported to the Director.

b) The home submitted a CIS report for an incident of alleged abuse of a resident.

Review of the home's investigation notes did not provide information in relation to follow-up action including long term actions to prevent the situation from occurring again. The notes did not indicate that the outcome of the investigation was discussed with the resident's SDM.

During an interview with the SDM they recalled meeting with Administrator and Dietary Manager in the initial stages of the investigation but they could not recall any subsequent meetings.

The Administrator and Dietary Manager shared that they remembered having a follow-up meeting with the SDM but there was no record of it.

The licensee failed to report to the Director the analysis and follow-up action including the long-term actions planned to correct the situation and prevent recurrence.

c) The home submitted a CIS report in relation to an incident of alleged abuse. In a review of the home's investigation notes and during an interview with a PSW it was verified that a resident reported concerns of alleged abuse by a specific PSW to a RPN.

The DOC shared that the CIS report did not include the name of the PSW that was present at the incident.

The licensee failed to ensure that the report to the Director included the names of any staff members present at the incident.

d) A CIS report was submitted to the MOHLTC for an incident of alleged staff to resident verbal abuse. The resident identified the three staff involved in the incident but their names were not included on the CIS report.

In an interview with the DOC they said that their investigation included interviews with the staff accused of verbally abusing the resident, but missed those staff names on the CIS report.

The licensee failed to ensure that CIS report to the Director included the names of

all staff members involved in the incident.

Additional Required Actions:

CO # - 001, 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm to the resident.

2. abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

a) A written statement from a family member indicated that they spoke with the DOC about their concerns of potential resident abuse. The family member then filed a report with the Ontario Provincial Police.

A RPN said that the identified resident alleged on more than one occasion that they may be a victim of abuse. When asked if they reported this, the RPN said they told the Administrator.

The DOC stated that it was brought to their attention by a family member of a resident that the resident may be a victim of abuse. When asked if anyone had spoken with the resident the DOC said they could not recall. The DOC said they spoke with the Administrator about the situation of alleged abuse.

The Administrator stated that they did not interpret the first few days of the concern as grounds for a critical incident report. The DOC acknowledged that the alleged abuse was not reported to the Director immediately.

b) A CIS report was submitted to the MOHLTC for an incident in which an email was sent to the DOC regarding several residents that were not provided with continence care on a night shift.

The home's investigation record included a copy of an email sent by the RPN to the DOC. The email stated that staff had brought to the RPN's attention several residents that had not been provided with continence care on night shift.

During interviews with two PSWs they stated that on two consecutive mornings when they started their shift they found a number of residents who had not been provided with continence care. They called the RPN so that they would see the resident's condition. The first day the RPN sent a message to the DOC and the second day a PSW said they called the DOC and left a message to come up to the floor to see what they had found that morning.

The DOC said they did not see the email when it was sent and it was not until a staff member asked them about the incident that they went back and looked at their emails. It was at that point, 15 days later, that they reported the incident to the MOHLTC. The DOC acknowledged that they did not go to the unit to see the

staff after picking up the message and they had not immediately reported the incident of alleged neglect or incompetent care to the MOHLTC.

c) The home submitted a CIS report to the MOHLTC which stated that the DOC had received an email that was dated three days earlier from a RPN which stated that a resident reported that a staff member had been rough during the provision of care. The RPN noted in the email that the resident had expressed concerns about a specific staff member.

Interview with the RPN and the home's investigation notes showed that an email was sent to the DOC regarding this concern on a specified date and the CIS report was not submitted to the MOHLTC until three days later.

The DOC shared that they did not check their emails on the weekend and acknowledged that they did not report the incident of alleged abuse to the Director immediately.

The licensee failed to ensure that when a person had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director and the information upon which it was based.

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to provide for a staffing mix that was consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation.

Several complaints/concerns were received by the MOHLTC in relation to staffing shortages at the home which were negatively impacting residents' care and residents' rights.

A staff member stated that staffing shortages in the home were critical and had been for some time. Resident care had been affected as residents did not always receive baths, mouth care, and toileting consistent with their assessed care needs. They recalled a recent five day period where no baths were completed. Several staff had quit, including long-term employees due to the heavy workload from working short, and newly hired staff did not stay. Part-time staff were being maximized to full-time leaving no part-time staff to draw from. The staff member said there was no support or assistance from the Administrator or DOC.

In interviews with multiple staff including PSWs, Housekeepers, and registered

staff they shared that residents were not always receiving their baths, oral care, toileting, nourishment, and food was not served hot. Staff were using lifts independently during transfers putting residents at risk. If residents or family members complained to management, those residents received their bath. Staff had requested to work 12 hour shifts but management and the union did not agree to it. The part-time staff were working full-time hours so there were no staff available for call-ins. Many staff were working double shifts and were exhausted. There was no support from the management in the home and they were not visible on the units.

1. The DOC provided a copy of the daily required staffing complement for the home which was made up of six resident care units (24 residents each) over three floors:

There was a RN Support Role position but the individual had been off and had not been replaced.

The Assistant Director of Care and Clinical Care Coordinator positions were vacant.

The Ward Clerk and an Inspector reviewed the daily assignment sheets for a two month period. There was documented evidence that on 58 of 62 (93.5 per cent) days the home was without the full complement of PSW's, with one or more PSW shifts not filled on those days, as well as some registered staff vacancies.

2. The Ward Clerk said staffing had not been as critical as it was now. Many staff worked overtime and double shifts to ensure coverage. The Ward Clerk said that they tried to catch up on missed baths but, for the most part, it did not happen. Missed baths were documented in the bath binder and kept by the Ward Clerk.

a) Review of the bathing records identified that 14 of 141 (9.9 per cent) residents received all nine of their scheduled baths in a specified month and 11 of 138 (7.9 per cent) residents received all nine of their scheduled baths the next month. A random selection of 20 residents' bathing records for a two month period revealed that the identified residents missed between 27.7 per cent and 55.5 per cent of their scheduled baths.

b) A resident said that the home was always short staffed and it was particularly bad on weekends. The resident said they missed one bath in a specified month

and four baths the next month. When asked by the Inspector if they had spoken to anyone, the resident said they get put off when they have tried to see the DOC. The Administrator was never available and did not get back to them.

c) A resident stated they had missed baths, especially on Saturdays because they were short staffed. The resident missed their bath the previous day and told the RPN they wanted to speak to the Administrator. It was only after they spoke with the Administrator that they received their bath.

d) A Complaint was received by the MOHLTC action line regarding multiple care concerns and no baths provided on a specified date for an identified resident. Review of the clinical record identified that the resident was not scheduled for a bath on the specified date as per the complaint received, however, they were scheduled for a bath two days later, and there was no documentation that it was given. In a review of the progress notes, there were multiple entries for specific care to be completed weekly after baths. Documentation by the RPN stated that the resident did not receive a bath, therefore the specified care was not completed. A review of staffing shortages for the home on the specified date for the day shift revealed that the home was short a bath shift PSW on second floor and third floor, as well as a PSW on the day shift from 0600 to 1400 hours. The home was short an evening bath shift PSW, as well as three PSWs from the hours of 1400 to 1800 hours and one PSW from the hours of 1600 to 1800 hours.

e) A CIS report was submitted to the MOHLTC which made reference to a written complaint received by the home with regards to concerns surrounding bathing for a resident. The complaint stated that the resident was not getting their baths twice a week and on many occasions over a specified two month period they had not been given it at pre-arranged time to allow for extra support. What they were finding was that the baths were either not being given at all or they were taking place at a time other than what was scheduled.

Review of the POC bath report for the resident over a 17 day period, identified that the resident received three out of five baths. Documentation stated that of the baths given, not all were given at the scheduled times.

During interviews with a PSW and RN they said that the residents' SDMs had arranged with the home a specific schedule for baths to ensure that extra support could be provided. The PSW and RN shared that often baths did not take place

at this time because the bath shift was pulled to work in another area of the home because they were short staffed. The DOC stated that the resident did not always get a bath twice a week, and when they were bathed it was not always at the requested time because of short staffing.

f) A family member shared that a resident had not received scheduled baths and bathing records confirmed that the resident missed one bath in a specified month and three baths the next month due to staffing shortages.

3. A RPN and a RN said the home had been extremely short-staffed and it was especially bad on one particular weekend. The staff said that there was no support from the management of the home.

Several RPNs said they worked as both an RPN and PSW, due to working short, on a number of occasions over a specified two month period. The RPNs said there were times on the night shift when the secure unit was left unattended as they needed the help of the PSW. The RPNs said that when they were short it was the homes expectation that they perform their own duties as well as those of the PSW. Treatments and assessments were not always completed, especially on weekends. Baths were not done and residents got toileted only if they asked. There was no support from the Administrator or DOC and they never came in on weekends.

A RN shared that they were quite concerned with the staffing process in the home. The centralized scheduling system was adding extra work for the charge nurse and they had spent a great deal of their shift that day speaking with staff that called in because they had received messages from the centralized scheduling system. As a result, they were not able to complete the required resident care. They would need to stay overtime in order to complete at least three treatments and several other assessments. The RN expressed their concern that the chronic staff shortage was having a negative impact on resident care. On one particular unit there were at least five residents with wounds where there used to be none. This was in part because there was not sufficient staff to turn / reposition residents as often as needed. Falls in the home had increased because staff were not able to monitor residents as closely. The RAI Coordinator provided the falls list for a two month period, which indicated there had been 111 falls.

4. A PSW shared that there were two incidents in one month where they were

working short on the secure unit during the night shift. A resident who exhibited responsive behaviours was observed going into other resident rooms. The plan of care for the resident recommended that two staff provide care for the resident. On both nights in question they were the only staff on the unit and had to deal with situations involving the resident which posed a potential risk to other residents as well as the PSW.

5. A RN shared that on a specified date they received a phone call alerting them that there was an intruder in the home. A RPN said that on the same night they received a call from police saying they were at the front door. They explained that they were looking for a missing person and believed they may be on the premises.

During interviews with the staff that worked the night of the incident, they said they were short two PSWs. The normal staffing on nights was one RN, one RPN, and six PSWs. On this shift the RN and RPN were pulled to work the floor because of the PSW shortage. The RPN and one PSW were to be on second floor with one staff on 2 South (secure unit) at all times; the RN and one PSW were on third floor, however the RN had to leave third floor at times to go to other floors when assessments or medications were needed; and two PSWs were on fourth floor.

The RN said that on the specified night shift from the time they received the call about the intruder in the home until they escorted the police and the intruder out of the home at 0330 hours they were involved doing a search of the home to locate the intruder and were not able to assist the PSW on third floor with resident care. The PSW from second floor said that during the same time period they were running the stairs to check to ensure doors to balconies were locked and assisting the RN and the police with searching the building for the intruder. They were away from 2 West some time, but could not give an exact time frame.

The RPN said they remained in the secure unit except for when they were told by the RN to go find the police and send them to 3 South as they were needed there. The RPN said they were not gone long but when they returned to 2 South a resident was up wandering on the unit unsupervised. The resident was known to have responsive behaviours so they directed them back to their room.

Review of the call bell records for shift in question showed that a resident on 2 West who was totally dependent on staff rang their call bell and it was 30 minutes

before it was cancelled.

In an interview with one of the PSWs they shared that they had started work at 1400 hours and agreed to stay until 0600 hours the next day. They did not want to leave the other PSW to provide care for 48 residents.

During an interview with another PSW they shared that on the night of the incident they were the only PSW working on the third floor to provide care for 48 residents. The PSW shared that there were many residents on third floor that required two staff to change and reposition them in bed but there wasn't sufficient staff. The staff member said that they barely had time to do basic cares and answer call bells.

The RN said that on the night of the incident they had not checked all the exterior doors because they were dealing with the staffing shortage. Their normal practice was to check the doors just after the shift started. Instead they were on the third floor assisting the PSW with resident care and in between had gone down to second floor to help the RPN with post falls assessments as there had been two falls. The RN also said that had they been fully staffed, they would have been on fourth floor and would have recognized the person as an intruder.

When the Administrator was asked about the staffing complement during the night that the intruder was in the home, they said they were not sure but believed they were one PSW short.

6. In an interview with the Administrator they were asked if they were aware of the staffing shortages for the upcoming week-end. The Administrator said they were using centralized scheduling and would receive an alert on Thursdays but had not received one. The Inspector said the Ward Clerk was off on Thursday and centralized scheduling had only replaced one half RPN shift. The Inspector explained that combined, there were fourteen unscheduled shifts for Saturday and Sunday. The Administrator said they were not aware of that. The Inspector said the DOC was aware, but did not inform the Administrator. Staffing was critical and the Inspectors were concerned regarding the number of unscheduled shifts and how the home was planning to ensure resident care and safety over the weekend. The Inspector asked what the staffing plan was for the week-end and the Administrator had no answer.

On a specified date two Inspectors attended the home to assess staffing, as there

were anticipated significant shortages. Upon entry to the home a RN shared the following staffing shortages for the weekend:

Saturday - short all three day bath shifts, the evening bath shift and evening float; on days short 1.5 PSWs and .5 RPN; on evenings short 3 PSWs and 1.0 RPN. A PSW agreed to do a double to cover one of the evening shifts.

Sunday - short all three day bath shifts, the evening bath shift and evening float; on days short .5 RN and .5 RPN; on evenings short 1.75 RPN (DOC came in to cover for one position); 4.0 PSWs - staff from day shift stayed to cover a part of the shift but after dinner there was just one PSW on each floor; on nights short 1.0 PSW but an evening staff agreed to stay until 0200 hours.

Observations of the dining room on a specified unit that evening revealed that 22 residents were present for dinner. Three staff were present to assist; the RPN, an activation aide and one PSW who had agreed to stay after their day shift ended until 1800 hours because they were short of staff. Two family members were also present to assist residents with their meals. The RPN said that because they were so short of staff, medications would start at 1900 hours, but they would have to stop and start the administration as the PSW would require assistance with resident care.

On the same day at 1900 hours the Director of Health Services arrived at the home. An Inspector expressed their concerns related to critical staffing shortages, potential safety risk to residents and staff, lack of bathing and care provision.

A family member was concerned about the amount of staff available to provide care and assistance for residents. The family member said they visited every day at lunch to assist a specific resident and had seen the shortages. On one particular weekend there were only two PSW's and no volunteers to assist with lunch and there were many residents that needed help with eating.

7. A PSW expressed concerns that staffing on the weekend after inspectors were in the home was just as bad as the previous weekend. The PSW shared that none of the management staff came in to help.

Review of the Human Resources reports provided for the identified weekend the following was noted:
1) On the Saturday evening shift they were short one RN from 1400-1800 hours,

one RPN from 1400 to 1800 hours and two RPNs from 1800-2200 hours. The home was short four PSWs from 1800 to 2200 hours.
2) On the Sunday evening shift they were short one RN from 1400 to 1800 hours, one RPN from 1800 to 2200 hours and four PSWs from 1800 to 1900 hours and five PSWs from 1900 to 2200 hours. On nights they were short one PSW from 0200 to 0600 hours.

The home was also without an RN in the building on the Friday of that weekend for a one hour period. The DOC shared that they were aware of this shortage. The Administrator said in their email that they were not aware that there was no RN in the building for that hour on the evening shift.

8. A resident reported that they had been left in pain on a specified date. When staff came to assist the resident with their activities of daily living the resident asked them for their medication to keep pain under control. The resident said that the medication was not brought for another 45 minutes.

In an interview with the RPN working the day of the incident, they shared that they were working short that day and as a result were late giving the identified resident their medication. The RPN explained that they had to give medications on both the west and south units. The RPN said that they often worked short a registered staff on the floor and were then required to give medications to 48 residents. In those situations it was almost impossible to give all medications at their scheduled times.

Review of the employee schedule listing for the specified date and shift showed that they were short one RPN on the floor where the identified resident resided.

The licensee failed to provide for a staffing mix that was consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation including that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and various care provisions were being met.

Additional Required Actions:

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

(A1)
The following order(s) have been amended: CO# 003

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

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,
(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;
O. Reg. 79/10, s. 50 (2).

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 a resident that was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of the resident from the hospital.

A complaint submitted to the MOHLTC and a related CIS report outlined several concerns brought forward by a resident's SDM which included wound care.

On a specified date the resident was admitted to Brucelea Haven with areas of altered skin integrity. The resident required staff assistance with their care. A short time later the resident was taken to the hospital and subsequently admitted. The resident was treated in the hospital and returned to the home.

The discharge summary note from the Physician at the hospital stated that the

resident had areas of altered skin integrity.

A review of the resident's clinical record identified that a skin assessment had not been completed by a member of the registered staff upon the resident's return from hospital.

The RN stated that the resident had altered skin integrity but they were not able to find a head to toe assessment nor a skin assessment completed when the resident returned from hospital.

The Licensee has failed to ensure a resident that was at risk of altered skin integrity received a skin assessment by a member of the registered nursing staff upon return of the resident from the hospital.

2. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A CIS report was submitted to the MOHLTC through the after-hours reporting line to inform the Director of improper care of a resident who was transferred to hospital.

O. Reg. 79/10, s.50 (3) states “altered skin integrity means potential or actual disruption of epidermal or dermal tissue.

The CIS report stated that the RPN assessed the resident throughout the day and contacted the emergency department physician who ordered medication. The RPN coming on shift assessed the resident as having developed a specific condition and transferred the resident to hospital for further assessment.

Progress notes for the resident identified that over a three day period the resident exhibited worsening symptoms of altered skin integrity.

Two PSWs stated that prior to the resident going to hospital they had exhibited the signs outlined above. They had reported this to the registered staff several times.

Review of the resident's clinical record identified that there was no documentation in the electronic treatment administration record (eTAR) nor was there a skin/wound assessment completed for the resident's altered skin integrity.

The RPN shared that it was the home's expectation that a skin/wound assessment be completed weekly for altered skin integrity and that it was to be documented in the assessment section of the resident's electronic chart as well as on the eTAR. The RPN said that a skin/wound assessment had not been completed for for the identified resident's altered skin integrity and this was acknowledged by the DOC.

3. The Licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown pressure ulcers skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.

A Critical Incident was received by the MOHLTC through the after-hours reporting line to inform the Director of an incident of alleged improper care of a resident who was transferred to hospital.

Review of the resident's progress notes over a 12 day period identified worsening symptoms of altered skin integrity. During the 12 day time period the resident received limited treatment to address pain, swelling and other changes in skin. The RPN assessed the resident on the 12th day and based on findings, consulted with the physician who recommended transfer to hospital.

There were no pain assessments and no skin assessments completed after a specified time on the day the resident was sent to hospital, despite multiple entries stating the resident was in pain. The resident was not given any medication for pain in the 12 hours prior to going to hospital.

The home's Pain Management Program policy stated that the registered staff would evaluate pain during a change in health status where the resident showed/expressed episodes of uncontrolled pain.

In an interview with a PSW they said they were frustrated at that time because the resident exhibited signs of altered skin integrity and their mobility was compromised. The PSW stated that they reported their concerns to the nurse.

A RPN said that on the day the resident went to hospital they felt the resident's pain was managed as they stated the pain went away with repositioning. The resident's condition was such that the RPN contacted a Physician for direction. When asked if there was a care plan for pain, or altered skin integrity, the RPN stated that they did not think so.

A second RPN said that they could tell by the resident's face that they were in pain and did not get relief. The RPN said that a wound assessment should have been done daily and changes documented in the progress notes, as well as a full skin assessment done weekly with an eTAR notation and pictures taken of the impairment. The RPN verified that a care plan entry should be made in the care plan for pain, infection and skin/wound, however, there were no care plans and no interventions in place to manage the resident's pain or deteriorating condition.

In an interview with the DOC they said that when a resident had pain that was not managed, a pain assessment should be completed. The DOC shared that they did not have a process for following up on clinical concerns in the home on a daily basis.

The resident's pain was not well managed and the resident was not adequately assessed during the 12 day period before transfer to hospital. Multiple entries were made in the progress notes, where the resident was identified as being in pain.

The Licensee has failed to ensure that when a resident exhibits altered skin integrity, including skin breakdown pressure ulcers skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.

4. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Progress notes for a resident identified that over a three day period the resident exhibited worsening signs of altered skin integrity.

During a review of the resident's clinical record there was no evidence that a

referral was made to the Registered Dietitian (RD), nor were there any assessments to confirm that the RD was aware that the resident had any areas of altered skin integrity.

In an interview with a RPN they shared that there was no a referral made to the RD for the identified resident in relation to their altered skin integrity.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implement

5. The licensee has failed to 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.

A complaint was submitted to the MOHLTC in relation to several concerns brought forward by a resident's SDM which included wound care.

On admission to the home the resident had areas of altered skin integrity. The resident required staff assistance for care.

In a review of the resident's clinical record there was no evidence of a weekly wound assessment during one week of the first month and five weeks in the second month prior to the resident going to hospital.

A review of the resident's eTAR showed that weekly wound assessments were to be completed in PCC for the areas of altered skin integrity. For the first month there were registered staff signatures documented weekly except on one specified date where it said to refer to the progress notes. In the progress notes it stated that the skin assessment was not completed. The resident's eTAR for the second month identified registered staff signatures for the five weeks; however there were no wound assessments completed in PCC.

In an interview with a RN they said that weekly wound assessments should be completed in the assessment section on PCC for each of the areas of altered skin integrity and there were none completed in the second month.

The licensee has failed to 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.

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 #5: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

a) CIS report was submitted to the MOHLTC in relation to an incident of alleged improper care / neglect of a resident. According to the report an email was received by the DOC from a RN which stated that a resident was left unattended in the midst of care for a lengthy period.

Review of progress notes on PCC for the resident indicated that on a specified

date and time the resident was observed to be left unattended in the midst of care for a lengthy period as reported by the PSW and the resident was at increased risk of further behaviours and of injury. POC documentation for the identified resident on that shift showed that documentation was completed to indicate care was provided.

The Resident Assessment Instrument Minimum Data Set (RAI MDS) for the resident documented they had some degree of incontinence. The resident's care plan documented that staff were to provide assistance for the identified care activity and monitor the resident.

Two PSWs said that the resident required staff assistance with specified activities of daily living. A PSW acknowledged that they worked the adjacent wing the night of the incident where the resident was left unattended for a lengthy period of time and they were not made aware of this by their co-worker.

The home's investigation file included an email from the RN #147 to the DOC which stated that a resident was left unattended during care for a lengthy period of time. The RN stated that they had been on the unit several times during the night but was only notified of this at the end of the shift when they were giving the resident their morning medications.

A summary of the home's investigation documented that the PSW acknowledged that they left the resident unattended during care for a lengthy time period but had gone in to check on them.

The DOC stated that the PSW had not been removed from working their next shift on the same unit, pending an investigation as they had not been aware of the incident until they returned to work two days later. The DOC stated that the resident should not have been left unattended during care for that length of time.

b) A CIS report was submitted to the MOHLTC for an incident where an email was sent to the DOC by a registered staff regarding several residents that were not provided continence care on the night shift.

The home's investigation record included a copy of an email sent by a RPN to the DOC. The email stated that staff had brought to the RPN's attention several residents that were not provided with continence care during the night shift. The RPN said they observed one of the residents and it was evident they had not

been provided with continence care. The email identified the PSW that worked the night shift on that unit.

The plan of care for the identified residents specific to continence indicated that all of the residents had some degree of incontinence.

During interviews with two PSWs they stated that on two consecutive days they found several residents that did not appear to have had continence care on the previous shift. They notified the RPN of the incident and showed them the state of one of the residents. The first day the RPN sent a message to the DOC and the second day one of the PSWs called the DOC and left a message to come up to the floor to see what they had found that morning when they went to provide care to residents. The staff said that the DOC did not come to the floor to follow-up. The PSWs said that when they came on shift that morning the night PSW did not share anything with regards to residents. While they were waiting for shift report one of the identified resident's call bell had gone off and the night PSW went to answer the bell. They returned moments later and did not say anything about the resident needing care.

In an interview with the bath PSW they recalled that morning shift and finding two residents that had not been provided with continence care. The PSW said they often worked the night shift and both residents usually rang frequently to use the bathroom. It was not possible for these residents to be in this state if they were provided continence care. The PSW said they reported what they observed to the RPN who said they would notify the DOC.

The RPN said that they recalled the incident in question fairly well because so many residents were impacted. The bath PSW and two other PSWs all came to report that they found several residents that had not had continence care when they went to get them up. The degree of incontinence was not normal for the resident and would not have been possible if the resident was provided continence care during the previous shift.

In an interview with the PSW that worked the night shift they said that when they worked nights they would do rounds with the PSW on the other unit. They usually did rounds around 0300 hours and would document whether a resident was continent or incontinent and if they were changed at that time. The PSW said they could not recall the shift in question nor could they recall the identified residents and care provided. Investigation records included an interview with the PSW

conducted by the DOC. At that time the PSW acknowledged that they were working the specified night shifts and said that they checked all the residents prior to the end of their shift around 0420 hours and none of them needed continence care. When asked if one of the resident's call bell had gone off at the end of their shift the PSW could not recall.

Review of the call bell records for the specified date indicated that a bell had gone off for the specified resident just prior to the end of night shift and the staff went in and cancelled the bell. Based on call bell records, the staff member was in the room less than one minute.

Point of Care documentation on the specified night shift for the five identified residents with respect to continence was completed by the night PSW before 2330 hours. There was no documentation after this time period.

The DOC stated that during the investigation of the incident they reviewed documentation done just after 2300 hours for three identified residents. They noted that after that there was no documentation in relation to continence, but the staff member said they checked the residents and they did not require continence care. The DOC said that they also checked the plans of care for each resident and found that each of them was frequently incontinent. When asked if they recalled getting a phone call from one of the staff on the floor to come up to see the state of the residents on either morning, the DOC said that they recalled picking up a message the day after it was left but did not go to the floor.

The licensee failed to ensure that five residents were free from neglect by staff in the home.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Findings/Faits saillants :

1. 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; (b) the goals the care is intended to achieve; and (c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

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

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. s. 6. (7)

The plan of care for a resident identified that the resident was a risk for falls. Interventions were in place to mitigate the risk of falls.

A CIS report stated that the resident sustained a fall and was found beside their bed on a specified date. On assessment the resident exhibited signs of injury.

In an interview with a PSW they said that on the evening of the incident they remembered that there was a new staff member orienting on their unit. They

recalled that the new staff member had put the resident to bed. When a co-worker found the resident on the floor they noted that one of the interventions identified to mitigate the risk of falls / injury had not been in place at the time of the fall.

The home's investigation report signed by the DOC and in an interview with the DOC they acknowledged that the plan of care for the resident was not followed with respect to falls and injury prevention.

The licensee failed to ensure that the care set out in the plan of care for the resident with respect to falls was provided as per the plan.

2. The licensee failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provide direct care to the resident. s. 6. (1) (c)

a) During an interview with a resident they shared that there were times when they rang the bell to use the washroom and staff would not come. They waited so long that they had accidents.

In an interview with a PSW they said that they usually toileted the resident at regular intervals and sometimes more often if the resident requested. They said that the resident was at times incontinent but when toileted regularly the resident was kept more continent. The PSW logged into POC to see if there was any direction with respect to toileting for the resident. The PSW said that there was no direction in POC or the kardex as to when to toilet the resident. When the PSW was asked how newer staff would know when and how to toilet the resident, they said that they would not know unless another staff member more familiar with the resident could direct them.

During an interview with the resident's substitute decision maker (SDM) they shared that the resident had expressed that they were not satisfied with the care provided especially related to toileting because they often had to wait for staff to take them.

Review of the resident's plan of care related to toileting and continence identified that the resident required staff assistance, but the level of care and staff required was not clear and there was no clear direction to staff with respect to the care to be provided over the different shifts.

The DOC reviewed the resident's care plan and acknowledged that it did not provide clear direction in relation to toileting and continence care.

b) A written complaint and related CIS report were submitted to the MOHLTC to inform the Director of concerns involving personal care, medication administration and wound care.

In an interview with the resident's SDM they shared that when they came to visit the resident they were eating foods that were inappropriate for their diagnosis. The SDM stated that they shared their concerns with the staff and reminded them that the the resident had a specified diagnosis and should not be given these items.

In a review of an email concern sent to the DOC by the SDM it stated that when they came to visit the resident the RN was not aware of the level of staff assistance for the resident's care. At the time of the visit the number of staff providing care was not consistent with the plan of care direction.

A review of the resident's care plan stated that they liked to eat specific items. There was no indication in the resident's plan of care that these items should be limited in relation to the resident's diagnosis.

A review of the resident's care plan stated that a specified number of staff were to simultaneously provide care to expedite the process and to improve acceptance of care.

In a review of the document titled Collaborative meeting for the identified resident and presented to unit staff, it stated that when providing care a specified number of staff were to be present.

A review of progress note documentation identified a note which related to a meeting which took place several days earlier. The note provided clear direction with respect to care interventions for the resident.

In an interview with the DOC they said there was confusion in the plan of care. The DOC said that there was a gap when communicating interventions from the meeting to the staff providing care.

The licensee failed to ensure that there was a written plan of care for the

residents that set out clear direction to staff and others who provided direct care to the resident.

3. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident. s. 6. (2)

A resident developed pain in a specified area requiring specific medications. Over the next several days the RN documented that the resident showed signs of a worsening altered skin integrity and additional symptoms.

During a review of the resident's care plan on PCC the interventions for altered skin integrity were generic and not individualized to capture the resident's current assessment, goals or interventions.

The RPN shared that interventions related to resident care would be found in the resident care plan. The RPN documented assessments related to the resident having pain, altered skin integrity and administering medication and shared that they did not update the resident's care plan.

In an interview with another RPN they shared that they did not update the resident's care plan and that there were no entries for the resident in relation to worsening altered skin integrity or pain.

The DOC stated that a resident's plan of care consisted of the PCC chart and all PSWs had readability on kiosks in POC. The DOC shared that the care plan should be a living document and that it was reviewed quarterly, but they were working with staff to update the care plan. The DOC stated that it was their expectation that the plan of care for the resident be updated as care needs changed.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident's needs and preferences.

4. The licensee has failed to ensure that when care set out in the plan of care was not effective, the resident was reassessed and different approaches considered in the revision of the plan of care. s. 6. (11) (b)

A CIS report identified that a resident was found to be incontinent beyond what

would be expected.

The plan of care for the resident stated that interventions were in place to manage the incontinence.

During interviews with three PSWs they said that the resident was incontinent and interventions were in place to manage the incontinence. The staff said that the current interventions were not always sufficient to keep the resident comfortable. Staff could not recall any changes being made to address the resident's incontinence.

The RAI Coordinator / Continence lead provided a copy of an email from the DOC dated five months earlier which asked if a specific intervention could be provided for the resident to address their incontinence. According to a staff member the new intervention was trialed by staff for a short time but they saw no difference and it was discontinued. When asked if anything else had been done to address the continence issue the RAI Coordinator said nothing until just recently when another concern was brought forward.

The DOC said that because the resident's continence had not changed on their MDS assessment no further assessments were conducted. When asked if anything else had been done when initial interventions were not effective in managing the resident's continence, the DOC was not aware of anything.

The licensee failed to ensure that when care set out in the plan of care for a resident had not been effective for managing incontinence, that different approaches were considered in the revision of the plan of care.

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 #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, 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 the written policy that promotes zero tolerance of abuse and neglect of residents was complied with.

a) The home's policy titled Prevention of Abuse and Neglect of a Resident stated under the procedure that any employee or volunteer that witnesses an incident, or has any knowledge of an incident, that constitutes resident abuse or neglect, is responsible to immediately inform the Executive Director (ED)/Administrator and/or Charge Nurse in the home.

A CIS report was submitted to the MOHLTC on a specified date, for an incident that took place the previous day. The CIS report documented that a staff member witnessed another staff member leave a resident for an extended period when they had been identified as being incontinent.

The staff member reported the incident the next day but recognized that they should have reported the incident immediately.

In an interview with the DOC, they said that they became aware of the incident the following day after receiving an email from another manager with the staff member's concerns. The DOC said the expectation for reporting incidents of suspected abuse or neglect was to immediately report to the the Executive

Director (ED)/Administrator and/or Charge Nurse in the home.

b) On a specified date the DOC called the after- hours number of the MOHLTC to report that a resident's SDM had informed them that the resident was threatened by staff when they were incontinent. The next day the home submitted a CIS report to the Director.

Review of the homes' investigation notes showed that the RN had sent the DOC an email on a specified date stating that they spoke with the resident and the resident felt the incident took place last evening or the night before. The day after the email was sent the DOC interviewed the resident at which time the resident could not recall the staff's names or the date of the occurrence.

During an interview with the resident's SDM they recalled the resident expressing that they were in trouble because they had been incontinent. The resident felt the staff was not appropriate in how they spoke with them and it upset them. They felt that the incident may have happened that evening or the previous night. They could not recall the name of the staff but could describe them.

The home's policy titled Prevention of Abuse & Neglect of a Resident, Policy stated that as part of the investigation the Executive Director/Administrator or designate interviews the resident, other residents, or persons who may have any knowledge of the situation. If possible, include a management witness during interviews with all residents. The witness takes detailed notes of the conversation.

The DOC shared that during their investigation they did not contact the SDM for the resident that reported the incident. They shared that they interviewed the resident and they were not clear on when the incident happened. The DOC acknowledged that no other staff were interviewed.

The licensee failed to ensure that that the written policy to promote zero tolerance of abuse and neglect of residents was complied with.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the written policy that promotes zero tolerance of abuse and neglect of residents was complied with, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 97. Notification re incidents

Specifically failed to comply with the following:

s. 97. (2) The licensee shall ensure that the resident and the resident's substitute decision-maker, if any, are notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation. O. Reg. 79/10, s. 97 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident and the resident's substitute decision-maker, if any, were notified of the results of the investigation required under subsection 23 (1) of the Act, immediately upon the completion of the investigation.

The DOC called the after-hours number at the MOHLTC to report that a resident's SDM had informed them that the resident felt threatened by staff when they were incontinent.

The home submitted a CIS report that stated the resident's SDM advised an RN that while visiting the resident they expressed concerns that when they asked to use the bathroom, staff had not taken them, and as a result they were incontinent. The resident also expressed that staff made them feel they were in trouble because of the incident.

Review of the home's investigation notes was completed and inside the folder was a post-it note indicating that a follow-up message was left for the family.

During an interview with the resident's SDM they shared that the DOC had left them a message and when they returned the call they were informed that the concern was not founded. The resident's SDM shared that this update was provided very recently, more than a month after the incident.

Review of the CIS report identified that it was amended within 10 days of the alleged incident and a summary of the completed investigation provided.

During an interview with the DOC, they stated that they did follow up with the SDM but could not provide the date.

The licensee failed to ensure that the resident's SDM was notified of the results of the investigation, immediately upon completion of the investigation.

Issued on this 24th day of December, 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

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

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MARIA MCGILL (728) - (A1)
Inspection No. / No de l'inspection :	2018_580568_0014 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	003353-18, 003355-18, 003356-18, 003357-18, 003364-18, 003640-18, 003764-18, 003787-18, 004223-18, 005058-18, 006297-18, 006426-18, 008608-18, 010694-18, 011889-18, 013143-18, 015287-18, 016055-18, 018525-18, 018571-18, 018738-18, 018740-18, 019716-18, 020199-18, 023459-18 (A1)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 24, 2018(A1)
Licensee / Titulaire de permis :	Corporation of the County of Bruce 30 Park Street, WALKERTON, ON, N0G-2V0
LTC Home / Foyer de SLD :	Brucelea Haven Long Term Care Home - Corporation of the County of Bruce 41 McGivern Street West, P.O. Box 1600, WALKERTON, ON, N0G-2V0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Willie VanKlooster

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 Corporation of the County of Bruce, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 001

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

Linked to Existing Order / Lien vers ordre existant: 2017_610633_0023, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (1) Every licensee of a long-term care home shall ensure that,
(a) every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated:
(i) abuse of a resident by anyone,
(ii) neglect of a resident by the licensee or staff, or
(iii) anything else provided for in the regulations;
(b) appropriate action is taken in response to every such incident; and
(c) any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with. 2007, c. 8, s. 23 (1).

Order / Ordre :

The licensee must be compliant with s. 23. (1) of the LTCHA.

Specifically the licensee shall ensure that:
a) Every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations.
b) Any requirements that are provided for in the regulations, including but not limited to O. Reg. 79/10 s. 97 (1) (2) and s. 98, for investigating and responding as required are complied with.
c) That all components of the investigation are documented and the the home maintains the investigation record.

Ontario

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

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #004 from inspection 2017_610633_0023 issued January 9, 2018, with a compliance date of January 30, 2018.

The licensee was ordered to ensure that every alleged, suspected or witnessed incident of the following that the licensee knows of, or that is reported to the licensee, is immediately investigated: (i) abuse of a resident by anyone, (ii) neglect of a resident by the licensee or staff, or (iii) anything else provided for in the regulations, appropriate action is taken in response to every such incident; and any requirements that are provided for in the regulations for investigating and responding as required under clauses (a) and (b) are complied with.
Specifically, the licensee shall ensure that:
(i) The Administrator, the Director of Care, and all other management staff of the home will complete a comprehensive review of the process for investigating abuse and neglect, roles and responsibilities, as well as immediate and long term appropriate actions to be taken including but not limited to O.Reg. 79/10, s. 97 (1) (2) related to substitute decision-maker notifications and O.Reg. 79/10, s. 98 related to Police notification.
(ii) This process shall include documenting and maintaining investigation records.
(iii) This process shall be implemented in the home and documented.

The licensee completed steps (i) and (iii) but not step (ii). The licensee did not immediately investigate every alleged, suspected or witnessed incident of abuse of a resident by anyone and neglect of a resident by the licensee or staff,

a) On a specified date a resident reported to a Registered Practical Nurse (RPN) that a staff member left them unattended for a long time and was verbally abusive. The resident was not able to provide the RPN with the name of the staff, but did describe them. The DOC called the Ministry of Health and Long Term Care (MOHLTC) after-hours pager and the home submitted a Critical Incident System (CIS) report.

During an interview with the RPN they shared that what they recalled the resident reported was that the staff member did not allow the resident nourishment and the staff member was rough. The RPN said they did not know who worked that shift but they immediately reported it to the DOC.

During an interview with the staff member who provided care for the resident at the time of the alleged incident they denied the allegations. The staff member shared that they provided care to for the same resident that next shift.

The DOC stated that they were aware of the allegation of abuse on the day it was reported as they called the MOHLTC after-hours pager that day. The DOC said they started the investigation two days later as they were off work.

b) The home submitted a CIS report that stated the DOC received an email from a RPN which stated that a resident brought a concern forward that the staff that did their care was rough with them. The RPN noted in the email that the resident expressed concerns about a specific PSW.

Review of the home's investigation notes showed that the RPN sent the email to the DOC regarding this concern on a specified date. The CIS report was submitted three days later. The resident and the PSW were interviewed four days later by the DOC.

The DOC acknowledged that their investigation did not start until four days after the incident in question.

c) A CIS report was submitted to the MOHLTC for an incident of alleged improper care / neglect. According to the report an email was sent to the DOC regarding several residents that were not provided continence care during the night shift.

The home's investigation record included a copy of an email sent by a RPN to the DOC. The email stated that staff had brought to the RPN's attention several residents that were not provided with continence care during the night shift. The RPN said they observed one of the residents and it was evident they had not been provided with continence care. The email identified the PSW that worked the night shift on that unit.

The DOC stated that the email referred to in the CIS report must have gotten lost in their inbox. It was not until a staff member spoke with them two weeks later about the incident that the DOC went back to look at their emails. At that point the DOC said they commenced their investigation into the incident. The DOC said that they recalled picking up a message the day after it was left regarding an incident on the identified floor but did not go to investigate further.

The licensee failed to ensure that an alleged incident of neglect of residents was immediately investigated.

d) A written statement from a family member indicated that they spoke with the DOC and informed them about a concern they had regarding an identified resident in relation to potential abuse. The family member then filed a report with the Ontario Provincial Police.

A Registered Practical Nurse said that the identified resident alleged on more than one occasion that they may be a victim of abuse. When asked if they reported this, the RPN said they told the Administrator.

The DOC told the Inspector that it was brought to their attention by a family member of a resident that the resident may be a victim of abuse. When asked if anyone had spoken with the resident the DOC said they could not recall. The DOC said they spoke with the Administrator about the situation of alleged abuse. When asked if they had started an investigation into the allegation, they said no.

The Administrator said they became aware of the allegations of abuse from the DOC. When asked if they had investigation notes, the Administrator said all references were in the CIS report and they had no other investigation documentation. The Administrator said that the family member went to police about the incident and they thought the MOHLTC would see the CIS report and decide whether further investigation was warranted. When asked if they had interviewed the resident or those involved, the Administrator acknowledged they had not done this. The Administrator said they had not contacted authorities, but the family member contacted police.

The licensee failed to ensure that any alleged, suspected or witnessed incidents of abuse of a resident by anyone, and neglect of a resident by the licensee or staff, were immediately investigated.

The severity of this issue was determined to be level 2, potential for harm. The scope was a level 1, isolated, affecting three out of eighteen incidents. The home had a level 5 history with multiple non-compliance and one related order to the current area of concern:

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

Compliance order #004 issued January 9, 2018 with a compliance due date of January 30, 2018 (2047_610633_0023).

(155)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 03, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2017_610633_0023, CO #002;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: 1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 4. Misuse or misappropriation of a resident's money. 5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Order / Ordre :

The licensee must be compliant with s. 24. (1) of the LTCHA.

Specifically the licensee must:
1. Ensure that any person who has reasonable grounds to suspect that any of the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:
i) Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm.
ii) Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or risk of harm to the resident.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #002 from inspection #2017_610633_0023 served January 9, 2018, with a compliance date of January 30, 2018.

The licensee was ordered to ensure that a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident and abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director. That after normal business hours including weekends and statutory holidays, the immediate report of the incidents must be made using the Ministry's after hours emergency contact.

The licensee failed to immediately report alleged incidents of abuse and neglect of residents both during normal business hours, weekends and holidays.

a) A written statement from a family member indicated that they spoke with the DOC about their concerns of potential resident abuse. The family member then filed a report with the Ontario Provincial Police.

A RPN said that the identified resident alleged on more than one occasion that they may be a victim of abuse. When asked if they reported this, the RPN said they told the Administrator.

The DOC stated that it was brought to their attention by a family member of a resident that the resident may be a victim of abuse. When asked if anyone had spoken with the resident the DOC said they could not recall. The DOC said they spoke with the Administrator about the situation of alleged abuse.

The Administrator stated that they did not interpret the first few days of the concern as grounds for a critical incident report. The DOC acknowledged that the alleged abuse was not reported to the Director immediately.

b) A CIS report was submitted to the MOHLTC for an incident in which an email was sent to the DOC regarding several residents that were not provided with continence care on a night shift.

The home's investigation record included a copy of an email sent by the RPN to the DOC. The email stated that staff had brought to the RPN's attention several residents that had not been provided with continence care on night shift.

During interviews with two PSWs they stated that on two consecutive mornings when they started their shift they found a number of residents who had not been provided with continence care. They called the RPN so that they would see the resident's condition. The first day the RPN sent a message to the DOC and the second day a PSW said they called the DOC and left a message to come up to the floor to see what they had found that morning.

The DOC said they did not see the email when it was sent and it was not until a staff member asked them about the incident that they went back and looked at their emails. It was at that point, 15 days later, that they reported the incident to the MOHLTC. The DOC acknowledged that they did not go to the unit to see the staff after picking up the message and they had not immediately reported the incident of alleged neglect or incompetent care to the MOHLTC.

c) The home submitted a CIS report to the MOHLTC which stated that the DOC had received an email that was dated three days earlier from a RPN which stated that a resident reported that a staff member had been rough during the provision of care. The RPN noted in the email that the resident had expressed concerns about a specific staff member.

Interview with the RPN and the home's investigation notes showed that an email was sent to the DOC regarding this concern on a specified date and the CIS report was not submitted to the MOHLTC until three days later.

The DOC shared that they did not check their emails on the weekend and acknowledged that they did not report the incident of alleged abuse to the Director immediately.

The licensee failed to ensure that when a person had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director and the information upon which it was based.

The severity of harm for this issue was determined as a level 2, potential for harm. The scope was a level 1, with three out of eighteen residents affected. The home had a level 5 history as they had multiple non-compliances with at least one related order to the current area of concern:

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

Compliance order #002 issued January 9, 2018 with a compliance date of January 30, 2018 (2017_610633_0023)
(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 03, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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

Linked to Existing Order / Lien vers ordre existant: 2017_610633_0023, CO #003;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10. s.31(3):

Specifically the licensee must ensure:

1. That the staffing plan provides for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation.
2. That the home conducts and documents an evaluation of their staffing plan that includes but is not limited to:
a) A review of their current staffing pattern specific to Personal Support Worker hours on each home area to ensure there are enough direct care staff/hours to meet the residents assessed care and safety needs including twice weekly bathing according to preference, toileting routines, repositioning and monitoring, oral care, and assistance at all meals.
b) That the home conducts a review their staffing pattern with respect to registered staff hours on each home area to ensure there are enough staff to meet the residents assessed care and safety needs including timely medication administration, completion of assessments for altered skin integrity and post fall.
3. Management in the home are aware of daily staffing shortages that may impact resident care, that the shortages are tracked, and that there are detailed plans in place and implemented to ensure that residents get the care and assistance they need.

Grounds / Motifs :

1. The licensee has failed to comply with compliance order (CO) #003 from inspection 2017_610633_0023 issued January 9, 2018, with a compliance date of January 30, 2018.

The licensee was ordered to develop, implement and submit a plan to ensure the following:
1. That the staffing plan provided 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 this Regulation.
2. The licensee must review the homes staffing pattern regarding Personal Support Workers hours on each home area and ensure there are enough Personal Support Workers/direct care staff to meet the residents assessed care and safety needs

including bathing needs and preferences. Specifically resident's #006, #013 and #014 and all residents are bathed at a minimum of twice weekly, on their scheduled bathing day, by the method of their choice and more frequently as determined by the resident's hygiene requirements.
3. That a procedure for tracking, monitoring and documenting all residents bathing, including missed bathing, is developed and implemented including who will be responsible.

The licensee developed and submitted a plan for steps 1-3 but did not implement the plan.

In addition to the Follow up to CO #003, there were several complaints/concerns submitted to the MOHLTC, in relation to staffing shortages at the home which were negatively impacting residents' care and residents' rights.

A staff member stated that staffing shortages in the home were critical and had been for some time. Resident care had been affected as residents did not always receive baths, mouth care, and toileting consistent with their assessed care needs. They recalled a recent five day period where no baths were completed. Several staff had quit, including long-term employees due to the heavy workload from working short, and newly hired staff did not stay. Part-time staff were being maximized to full-time leaving no part-time staff to draw from. The staff member said there was no support or assistance from the Administrator or DOC.

In interviews with multiple staff including PSWs, Housekeepers, and registered staff they shared that residents were not always receiving their baths, oral care, toileting, nourishment, and food was not served hot. Staff were using lifts independently during transfers putting residents at risk. If residents or family members complained to management, those residents received their bath. Staff had requested to work 12 hour shifts but management and the union did not agree to it. The part-time staff were working full-time hours so there were no staff available for call-ins. Many staff were working double shifts and were exhausted. There was no support from the management in the home and they were not visible on the units.

1. The DOC provided a copy of the daily required staffing complement for the home which was made up of six resident care units (24 residents each) over three floors:

There was a RN Support Role position but the individual had been off and had not been replaced.

The Assistant Director of Care and Clinical Care Coordinator positions were vacant.

The Ward Clerk and an Inspector reviewed the daily assignment sheets for a two month period. There was documented evidence that on 58 of 62 (93.5 per cent) days the home was without the full complement of PSW's, with one or more PSW shifts not filled on those days, as well as some registered staff vacancies.

2. The Ward Clerk said staffing had not been as critical as it was now. Many staff worked overtime and double shifts to ensure coverage. The Ward Clerk said that they tried to catch up on missed baths but, for the most part, it did not happen. Missed baths were documented in the bath binder and kept by the Ward Clerk.

a) Review of the bathing records identified that 14 of 141 (9.9 per cent) residents received all nine of their scheduled baths in a specified month and 11 of 138 (7.9 per cent) residents received all nine of their scheduled baths the next month. A random selection of 20 residents' bathing records for a two month period revealed that the identified residents missed between 27.7 per cent and 55.5 per cent of their scheduled baths.

b) A resident said that the home was always short staffed and it was particularly bad on weekends. The resident said they missed one bath in a specified month and four baths the next month. When asked by the Inspector if they had spoken to anyone, the resident said they get put off when they have tried to see the DOC. The Administrator was never available and did not get back to them.

c) A resident stated they had missed baths, especially on Saturdays because they were short staffed. The resident missed their bath the previous day and told the RPN they wanted to speak to the Administrator. It was only after they spoke with the Administrator that they received their bath.

d) A Complaint was received by the MOHLTC action line regarding multiple care concerns and no baths provided on a specified date for an identified resident. Review of the clinical record identified that the resident was not scheduled for a bath on the specified date as per the complaint received, however, they were scheduled

for a bath two days later, and there was no documentation that it was given. In a review of the progress notes, there were multiple entries for specific care to be completed weekly after baths. Documentation by the RPN stated that the resident did not receive a bath, therefore the specified care was not completed. A review of staffing shortages for the home on the specified date for the day shift revealed that the home was short a bath shift PSW on second floor and third floor, as well as a PSW on the day shift from 0600 to 1400 hours. The home was short an evening bath shift PSW, as well as three PSWs from the hours of 1400 to 1800 hours and one PSW from the hours of 1600 to 1800 hours.

e) A CIS report was submitted to the MOHLTC which made reference to a written complaint received by the home with regards to concerns surrounding bathing for a resident. The complaint stated that the resident was not getting their baths twice a week and on many occasions over a specified two month period they had not been given it at pre-arranged time to allow for extra support. What they were finding was that the baths were either not being given at all or they were taking place at a time other than what was scheduled.

Review of the POC bath report for the resident over a 17 day period, identified that the resident received three out of five baths. Documentation stated that of the baths given, not all were given at the scheduled times.

During interviews with a PSW and RN they said that the residents' SDMs had arranged with the home a specific schedule for baths to ensure that extra support could be provided. The PSW and RN shared that often baths did not take place at this time because the bath shift was pulled to work in another area of the home because they were short staffed. The DOC stated that the resident did not always get a bath twice a week, and when they were bathed it was not always at the requested time because of short staffing.

f) A family member shared that a resident had not received scheduled baths and bathing records confirmed that the resident missed one bath in a specified month and three baths the next month due to staffing shortages.

3. A RPN and a RN said the home had been extremely short-staffed and it was especially bad on one particular weekend. The staff said that there was no support from the management of the home.

Several RPNs said they worked as both an RPN and PSW, due to working short, on a number of occasions over a specified two month period. The RPNs said there were times on the night shift when the secure unit was left unattended as they needed the help of the PSW. The RPNs said that when they were short it was the homes expectation that they perform their own duties as well as those of the PSW. Treatments and assessments were not always completed, especially on weekends. Baths were not done and residents got toileted only if they asked. There was no support from the Administrator or DOC and they never came in on weekends.

A RN shared that they were quite concerned with the staffing process in the home. The centralized scheduling system was adding extra work for the charge nurse and they had spent a great deal of their shift that day speaking with staff that called in because they had received messages from the centralized scheduling system. As a result, they were not able to complete the required resident care. They would need to stay overtime in order to complete at least three treatments and several other assessments. The RN expressed their concern that the chronic staff shortage was having a negative impact on resident care. On one particular unit there were at least five residents with wounds where there used to be none. This was in part because there was not sufficient staff to turn / reposition residents as often as needed. Falls in the home had increased because staff were not able to monitor residents as closely. The RAI Coordinator provided the falls list for a two month period, which indicated there had been 111 falls.

4. A PSW shared that there were two incidents in one month where they were working short on the secure unit during the night shift. A resident who exhibited responsive behaviours was observed going into other resident rooms. The plan of care for the resident recommended that two staff provide care for the resident. On both nights in question they were the only staff on the unit and had to deal with situations involving the resident which posed a potential risk to other residents as well as the PSW.

5. A RN shared that on a specified date they received a phone call alerting them that there was an intruder in the home. A RPN said that on the same night they received a call from police saying they were at the front door. They explained that they were looking for a missing person and believed they may be on the premises.

During interviews with the staff that worked the night of the incident, they said they were short two PSWs. The normal staffing on nights was one RN, one RPN, and six PSWs. On this shift the RN and RPN were pulled to work the floor because of the PSW shortage. The RPN and one PSW were to be on second floor with one staff on 2 South (secure unit) at all times; the RN and one PSW were on third floor, however the RN had to leave third floor at times to go to other floors when assessments or medications were needed; and two PSWs were on fourth floor.

The RN said that on the specified night shift from the time they received the call about the intruder in the home until they escorted the police and the intruder out of the home at 0330 hours they were involved doing a search of the home to locate the intruder and were not able to assist the PSW on third floor with resident care. The PSW from second floor said that during the same time period they were running the stairs to check to ensure doors to balconies were locked and assisting the RN and the police with searching the building for the intruder. They were away from 2 West some time, but could not give an exact time frame.

The RPN said they remained in the secure unit except for when they were told by the RN to go find the police and send them to 3 South as they were needed there. The RPN said they were not gone long but when they returned to 2 South a resident was up wandering on the unit unsupervised. The resident was known to have responsive behaviours so they directed them back to their room.

Review of the call bell records for shift in question showed that a resident on 2 West who was totally dependent on staff rang their call bell and it was 30 minutes before it was cancelled.

In an interview with one of the PSWs they shared that they had started work at 1400 hours and agreed to stay until 0600 hours the next day. They did not want to leave the other PSW to provide care for 48 residents.

During an interview with another PSW they shared that on the night of the incident they were the only PSW working on the third floor to provide care for 48 residents. The PSW shared that there were many residents on third floor that required two staff to change and reposition them in bed but there wasn't sufficient staff. The staff member said that they barely had time to do basic cares and answer call bells.

The RN said that on the night of the incident they had not checked all the exterior doors because they were dealing with the staffing shortage. Their normal practice was to check the doors just after the shift started. Instead they were on the third floor assisting the PSW with resident care and in between had gone down to second floor to help the RPN with post falls assessments as there had been two falls. The RN also said that had they been fully staffed, they would have been on fourth floor and would have recognized the person as an intruder.

When the Administrator was asked about the staffing complement during the night that the intruder was in the home, they said they were not sure but believed they were one PSW short.

6. In an interview with the Administrator they were asked if they were aware of the staffing shortages for the upcoming week-end. The Administrator said they were using centralized scheduling and would receive an alert on Thursdays but had not received one. The Inspector said the Ward Clerk was off on Thursday and centralized scheduling had only replaced one half RPN shift. The Inspector explained that combined, there were fourteen unscheduled shifts for Saturday and Sunday. The Administrator said they were not aware of that. The Inspector said the DOC was aware, but did not inform the Administrator. Staffing was critical and the Inspectors were concerned regarding the number of unscheduled shifts and how the home was planning to ensure resident care and safety over the weekend. The Inspector asked what the staffing plan was for the week-end and the Administrator had no answer.

On a specified date two Inspectors attended the home to assess staffing, as there were anticipated significant shortages. Upon entry to the home a RN shared the following staffing shortages for the weekend:

Saturday - short all three day bath shifts, the evening bath shift and evening float; on days short 1.5 PSWs and .5 RPN; on evenings short 3 PSWs and 1.0 RPN. A PSW agreed to do a double to cover one of the evening shifts.

Sunday - short all three day bath shifts, the evening bath shift and evening float; on days short .5 RN and .5 RPN; on evenings short 1.75 RPN (DOC came in to cover for one position); 4.0 PSWs - staff from day shift stayed to cover a part of the shift but after dinner there was just one PSW on each floor; on nights short 1.0 PSW but an evening staff agreed to stay until 0200 hours.

Observations of the dining room on a specified unit that evening revealed that 22 residents were present for dinner. Three staff were present to assist; the RPN, an activation aide and one PSW who had agreed to stay after their day shift ended until 1800 hours because they were short of staff. Two family members were also present to assist residents with their meals. The RPN said that because they were so short of staff, medications would start at 1900 hours, but they would have to stop and start the administration as the PSW would require assistance with resident care.

On the same day at 1900 hours the Director of Health Services arrived at the home. An Inspector expressed their concerns related to critical staffing shortages, potential safety risk to residents and staff, lack of bathing and care provision.

A family member was concerned about the amount of staff available to provide care and assistance for residents. The family member said they visited every day at lunch to assist a specific resident and had seen the shortages. On one particular weekend there were only two PSW's and no volunteers to assist with lunch and there were many residents that needed help with eating.

7. A PSW expressed concerns that staffing on the weekend after inspectors were in the home was just as bad as the previous weekend. The PSW shared that none of the management staff came in to help.

Review of the Human Resources reports provided for the identified weekend the following was noted:
1) On the Saturday evening shift they were short one RN from 1400-1800 hours, one RPN from 1400 to 1800 hours and two RPNs from 1800-2200 hours. The home was short four PSWs from 1800 to 2200 hours.
2) On the Sunday evening shift they were short one RN from 1400 to 1800 hours, one RPN from 1800 to 2200 hours and four PSWs from 1800 to 1900 hours and five PSWs from 1900 to 2200 hours. On nights they were short one PSW from 0200 to 0600 hours.

The home was also without an RN in the building on the Friday of that weekend for a one hour period. The DOC shared that they were aware of this shortage. The Administrator said in their email that they were not aware that there was no RN in the building for that hour on the evening shift.

8. A resident reported that they had been left in pain on a specified date. When staff came to assist the resident with their activities of daily living the resident asked them for their medication to keep pain under control. The resident said that the medication was not brought for another 45 minutes.

In an interview with the RPN working the day of the incident, they shared that they were working short that day and as a result were late giving the identified resident their medication. The RPN explained that they had to give medications on both the west and south units. The RPN said that they often worked short a registered staff on the floor and were then required to give medications to 48 residents. In those situations it was almost impossible to give all medications at their scheduled times.

Review of the employee schedule listing for the specified date and shift showed that they were short one RPN on the floor where the identified resident resided.

The licensee failed to provide for a staffing mix that was consistent with residents assessed care needs and that met the requirements set out in the Act and this Regulation including that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and various care provisions were being met.

The severity of this issue was determined to be level 3 - actual harm/risk, the scope of the issue was level 3 - widespread. The home had a level 5 compliance history as they had multiple non-compliance with at least one CO related to the current area of concern.
Compliance order #003 issued January 9, 2018, with a compliance due date of January 30, 2018 (2017_610633_0023).
(137)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 22, 2019(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 : 004

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 O. Reg. 79/10, s. 50. (2) (b) (i), (ii), (iii), and (iv).

Specifically the licensee must ensure that:
Resident #007, #057 and any other resident exhibiting altered skin integrity based on the definition for "altered skin integrity" in O. Reg. 79/10, s. 50 (3), including skin breakdown, pressure ulcers, skin tears or wounds:
1. 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;
2. Receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required;
3. 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;
4. Is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Grounds / Motifs :

1. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

A CIS report was submitted to the MOHLTC through the after-hours reporting line to inform the Director of improper care of a resident who was transferred to hospital.

O. Reg. 79/10, s.50 (3) states "altered skin integrity means potential or actual disruption of epidermal or dermal tissue.

The CIS report stated that the RPN assessed the resident throughout the day and contacted the emergency department physician who ordered medication. The RPN coming on shift assessed the resident as having developed a specific condition and transferred the resident to hospital for further assessment.

Progress notes for the resident identified that over a three day period the resident exhibited worsening symptoms of altered skin integrity.

Two PSWs stated that prior to the resident going to hospital they had exhibited the signs outlined above. They had reported this to the registered staff several times.

Review of the resident's clinical record identified that there was no documentation in the electronic treatment administration record (eTAR) nor was there a skin/wound assessment completed for the resident's altered skin integrity.

The RPN shared that it was the home's expectation that a skin/wound assessment be completed weekly for altered skin integrity and that it was to be documented in the assessment section of the resident's electronic chart as well as on the eTAR. The RPN said that a skin/wound assessment had not been completed for for the identified resident's altered skin integrity and this was acknowledged by the DOC.

The licensee failed to ensure that a resident exhibiting altered skin integrity received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. (155)

2. The Licensee has failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown pressure ulcers skin tears or wounds, receives immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.

A Critical Incident was received by the MOHLTC through the after-hours reporting line to inform the Director of an incident of alleged improper care of a resident who was transferred to hospital.

Review of the resident's progress notes over a 12 day period identified worsening symptoms of altered skin integrity. During the 12 day time period the resident received limited treatment to address pain, swelling and other changes in skin. The RPN assessed the resident on the 12th day and based on findings, consulted with the physician who recommended transfer to hospital.

There were no pain assessments and no skin assessments completed after a specified time on the day the resident was sent to hospital, despite multiple entries stating the resident was in pain. The resident was not given any medication for pain in the 12 hours prior to going to hospital.

The home's Pain Management Program policy stated that the registered staff would evaluate pain during a change in health status where the resident showed/expressed episodes of uncontrolled pain.

In an interview with a PSW they said they were frustrated at that time because the resident exhibited signs of altered skin integrity and their mobility was compromised. The PSW stated that they reported their concerns to the nurse.

A RPN said that on the day the resident went to hospital they felt the resident's pain was managed as they stated the pain went away with repositioning. The resident's condition was such that the RPN contacted a Physician for direction. When asked if there was a care plan for pain, or altered skin integrity, the RPN stated that they did not think so.

A second RPN said that they could tell by the resident's face that they were in pain and did not get relief. The RPN said that a wound assessment should have been done daily and changes documented in the progress notes, as well as a full skin

assessment done weekly with an eTAR notation and pictures taken of the impairment. The RPN verified that a care plan entry should be made in the care plan for pain, infection and skin/wound, however, there were no care plans and no interventions in place to manage the resident's pain or deteriorating condition.

In an interview with the DOC they said that when a resident had pain that was not managed, a pain assessment should be completed. The DOC shared that they did not have a process for following up on clinical concerns in the home on a daily basis.

The resident's pain was not well managed and the resident was not adequately assessed during the 12 day period before transfer to hospital. Multiple entries were made in the progress notes, where the resident was identified as being in pain.

The Licensee has failed to ensure that when a resident exhibits altered skin integrity, including skin breakdown pressure ulcers skin tears or wounds, received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection. (155)

3. The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.

Progress notes for a resident identified that over a three day period the resident exhibited worsening signs of altered skin integrity.

During a review of the resident's clinical record there was no evidence that a referral was made to the Registered Dietitian (RD), nor were there any assessments to confirm that the RD was aware that the resident had any areas of altered skin integrity.

In an interview with a RPN they shared that there was no a referral made to the RD for the identified resident in relation to their altered skin integrity.

The licensee failed to ensure that a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds was assessed by a registered dietitian who was a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration were implemented.
(155)

4. The licensee has failed to 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.

A complaint was submitted to the MOHLTC in relation to several concerns brought forward by a resident's SDM which included wound care.

On admission to the home the resident had areas of altered skin integrity. The resident required staff assistance for care.

In a review of the resident's clinical record there was no evidence of a weekly wound assessment during one week of the first month and five weeks in the second month prior to the resident going to hospital.

A review of the resident's eTAR showed that weekly wound assessments were to be completed in PCC for the areas of altered skin integrity. For the first month there were registered staff signatures documented weekly except on one specified date where it said to refer to the progress notes. In the progress notes it stated that the skin assessment was not completed. The resident's eTAR for the second month identified registered staff signatures for the five weeks; however there were no wound assessments completed in PCC.

In an interview with a RN they said that weekly wound assessments should be completed in the assessment section on PCC for each of the areas of altered skin integrity and there were none completed in the second month.

The licensee has failed to 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 severity of harm for this issue was determined to be a level 2, potential for harm. The scope was widespread, as it related to three out of three residents. The home had a level 2 history, with one or more unrelated non-compliances in the last 36 months.
(568)

Feb 08, 2019(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

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

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 : 005

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

Linked to Existing Order / Lien vers ordre existant: 2017_610633_0023, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:
1. Ensure that residents #005, #008, #009, #010, #051, and #052 and any other resident are free from neglect by the licensee or staff.

Grounds / Motifs :

1. The licensee failed to comply with compliance order #001 from inspection #2017_610633_0023 issued January 9, 2018, with a compliance date of January 30, 2018.

The licensee was ordered to protect resident's #016, #018, #017 and all residents from abuse by anyone, and ensure that resident #019 and all residents were not neglected by the licensee or staff.

The licensee protected resident's #016, #018 and #017 from abuse, and resident #019 from neglect, but it did not protect all residents from neglect by the licensee or staff.

a) A CIS report was submitted to the MOHLTC for an incident where an email was sent to the DOC by a registered staff regarding several residents that were not provided continence care on the night shift.

The home's investigation record included a copy of an email sent by a RPN to the DOC. The email stated that staff had brought to the RPN's attention several residents that were not provided with continence care during the night shift. The RPN said they observed one of the residents and it was evident they had not been provided with continence care. The email identified the PSW that worked the night shift on that unit.

The plan of care for the identified residents specific to continence indicated that all of the residents had some degree of incontinence.

During interviews with two PSWs they stated that on two consecutive days they found several residents that did not appear to have had continence care on the previous shift. They notified the RPN of the incident and showed them the state of one of the residents. The first day the RPN sent a message to the DOC and the second day one of the PSWs called the DOC and left a message to come up to the floor to see what they had found that morning when they went to provide care to residents. The staff said that the DOC did not come to the floor to follow-up. The PSWs said that when they came on shift that morning the night PSW did not share anything with regards to residents. While they were waiting for shift report one of the identified resident's call bell had gone off and the night PSW went to answer the bell. They returned moments later and did not say anything about the resident needing care.

In an interview with the bath PSW they recalled that morning shift and finding two residents that had not been provided with continence care. The PSW said they often worked the night shift and both residents usually rang frequently to use the bathroom. It was not possible for these residents to be in this state if they were provided continence care. The PSW said they reported what they observed to the RPN who said they would notify the DOC.

The RPN said that they recalled the incident in question fairly well because so many residents were impacted. The bath PSW and two other PSWs all came to report that they found several residents that had not had continence care when they went to get them up. The degree of incontinence was not normal for the resident and would not have been possible if the resident was provided continence care during the previous shift.

In an interview with the PSW that worked the night shift they said that when they worked nights they would do rounds with the PSW on the other unit. They usually did rounds around 0300 hours and would document whether a resident was continent or incontinent and if they were changed at that time. The PSW said they could not recall the shift in question nor could they recall the identified residents and care provided. Investigation records included an interview with the PSW conducted by the DOC. At that time the PSW acknowledged that they were working the specified night shifts and said that they checked all the residents prior to the end of their shift around 0420 hours and none of them needed continence care. When asked if one of the resident's call bell had gone off at the end of their shift the PSW could not recall.

Review of the call bell records for the specified date indicated that a bell had gone off for the specified resident just prior to the end of night shift and the staff went in and cancelled the bell. Based on call bell records, the staff member was in the room less than one minute.

Point of Care documentation on the specified night shift for the five identified residents with respect to continence was completed by the night PSW before 2330 hours. There was no documentation after this time period.

The DOC stated that during the investigation of the incident they reviewed documentation done just after 2300 hours for three identified residents. They noted that after that there was no documentation in relation to continence, but the staff member said they checked the residents and they did not require continence care. The DOC said that they also checked the plans of care for each resident and found that each of them was frequently incontinent. When asked if they recalled getting a phone call from one of the staff on the floor to come up to see the state of the residents on either morning, the DOC said that they recalled picking up a message the day after it was left but did not go to the floor.

b) CIS report was submitted to the MOHLTC in relation to an incident of alleged improper care / neglect of a resident. According to the report an email was received by the DOC from a RN which stated that a resident was left unattended in the midst of care for a lengthy period.

Review of progress notes on PCC for the resident indicated that on a specified date and time the resident was observed to be left unattended in the midst of care for a

lengthy period as reported by the PSW and the resident was at increased risk of further behaviours and of injury. POC documentation for the identified resident on that shift showed that documentation was completed to indicate care was provided.

The Resident Assessment Instrument Minimum Data Set (RAI MDS) for the resident documented they had some degree of incontinence. The resident's care plan documented that staff were to provide assistance for the identified care activity and monitor the resident.

Two PSWs said that the resident required staff assistance with specified activities of daily living. A PSW acknowledged that they worked the adjacent wing the night of the incident where the resident was left unattended for a lengthy period of time and they were not made aware of this by their co-worker.

The home's investigation file included an email from the RN #147 to the DOC which stated that a resident was left unattended during care for a lengthy period of time. The RN stated that they had been on the unit several times during the night but was only notified of this at the end of the shift when they were giving the resident their morning medications.

A summary of the home's investigation documented that the PSW acknowledged that they left the resident unattended during care for a lengthy time period but had gone in to check on them.

The DOC stated that the PSW had not been removed from working their next shift on the same unit, pending an investigation as they had not been aware of the incident until they returned to work two days later. The DOC stated that the resident should not have been left unattended during care for that length of time.

The licensee failed to ensure that residents were free from neglect by staff in the home.

The severity of this issue was determined to be a level 2, potential for harm to the residents. The scope of the issue was a level 2, pattern, as it related to six out of eighteen residents reviewed. The home had a level 5 history with multiple non-compliances and at least one related order to the current area of concern: Compliance order #001 issued January 9, 2018, with a compliance due date of

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

January 30, 2018 (2017_610633_0023)

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jan 03, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with s. 6. of the LTCHA.

Specifically the licensee must:
a) Ensure that the written plan of care for resident #020 and any other resident in relation to toileting; and resident #057 and any other resident in relation to nutrition and care provision; provides clear direction to staff and others who provide direct care to the resident.
b) Ensure that the care set out in the plan of care for resident #007 and any other resident is based on an assessment of the resident's needs and preferences specific to pain, altered skin integrity and infection.
c) Ensure that the care set out in the plan of care for resident #042 and any resident in relation to falls is provided to the resident as specified in the plan.
d) Ensure that resident #001 and any other resident is reassessed and the plan of care related to continence and toileting revised when care set out in the plan has not been effective, having considered different approaches in the revision of the plan of care.

Grounds / Motifs :

1. The licensee has failed to ensure that the care set out in the plan of care was based on an assessment of the resident and the needs and preferences of that resident. s. 6. (2)

A resident developed pain in a specified area requiring specific medications. Over the next several days the RN documented that the resident showed signs of a worsening altered skin integrity and additional symptoms.

During a review of the resident's care plan on PCC the interventions for altered skin integrity were generic and not individualized to capture the resident's current assessment, goals or interventions.

The RPN shared that interventions related to resident care would be found in the resident care plan. The RPN documented assessments related to the resident having pain, altered skin integrity and administering medication and shared that they did not update the resident's care plan.

In an interview with another RPN they shared that they did not update the resident's care plan and that there were no entries for the resident in relation to worsening altered skin integrity or pain.

The DOC stated that a resident's plan of care consisted of the PCC chart and all PSWs had readability on kiosks in POC. The DOC shared that the care plan should be a living document and that it was reviewed quarterly, but they were working with staff to update the care plan. The DOC stated that it was their expectation that the plan of care for the resident be updated as care needs changed.

The licensee failed to ensure that the care set out in the plan of care was based on an assessment of the resident's needs and preferences. (568)

2. The licensee has failed to ensure that when care set out in the plan of care was not effective, the resident was reassessed and different approaches considered in the revision of the plan of care. s. 6. (11) (b)

A CIS report identified that a resident was found to be incontinent beyond what would be expected.

The plan of care for the resident stated that interventions were in place to manage the incontinence.

During interviews with three PSWs they said that the resident was incontinent and interventions were in place to manage the incontinence. The staff said that the current interventions were not always sufficient to keep the resident comfortable. Staff could not recall any changes being made to address the resident's incontinence.

The RAI Coordinator / Continence lead provided a copy of an email from the DOC dated five months earlier which asked if a specific intervention could be provided for the resident to address their incontinence. According to a staff member the new intervention was trialed by staff for a short time but they saw no difference and it was discontinued. When asked if anything else had been done to address the continence issue the RAI Coordinator said nothing until just recently when another concern was brought forward.

The DOC said that because the resident's continence had not changed on their MDS assessment no further assessments were conducted. When asked if anything else had been done when initial interventions were not effective in managing the resident's continence, the DOC was not aware of anything.

The licensee failed to ensure that when care set out in the plan of care for a resident had not been effective for managing incontinence, that different approaches were considered in the revision of the plan of care. (568)

3. The licensee failed to ensure that there was a written plan of care for each resident that set out, clear directions to staff and others who provide direct care to the resident. s. 6. (1) (c)

a) During an interview with a resident they shared that there were times when they

rang the bell to use the washroom and staff would not come. They waited so long that they had accidents.

In an interview with a PSW they said that they usually toileted the resident at regular intervals and sometimes more often if the resident requested. They said that the resident was at times incontinent but when toileted regularly the resident was kept more continent. The PSW logged into POC to see if there was any direction with respect to toileting for the resident. The PSW said that there was no direction in POC or the kardex as to when to toilet the resident. When the PSW was asked how newer staff would know when and how to toilet the resident, they said that they would not know unless another staff member more familiar with the resident could direct them.

During an interview with the resident's substitute decision maker (SDM) they shared that the resident had expressed that they were not satisfied with the care provided especially related to toileting because they often had to wait for staff to take them.

Review of the resident's plan of care related to toileting and continence identified that the resident required staff assistance, but the level of care and staff required was not clear and there was no clear direction to staff with respect to the care to be provided over the different shifts.

The DOC reviewed the resident's care plan and acknowledged that it did not provide clear direction in relation to toileting and continence care.

b) A written complaint and related CIS report were submitted to the MOHLTC to inform the Director of concerns involving personal care, medication administration and wound care.

In an interview with the resident's SDM they shared that when they came to visit the resident they were eating foods that were inappropriate for their diagnosis. The SDM stated that they shared their concerns with the staff and reminded them that the the resident had a specified diagnosis and should not be given these items.

In a review of an email concern sent to the DOC by the SDM it stated that when they came to visit the resident the RN was not aware of the level of staff assistance for the resident's care. At the time of the visit the number of staff providing care was not consistent with the plan of care direction.

A review of the resident's care plan stated that they liked to eat specific items. There was no indication in the resident's plan of care that these items should be limited in relation to the resident's diagnosis.

A review of the resident's care plan stated that a specified number of staff were to simultaneously provide care to expedite the process and to improve acceptance of care.

In a review of the document titled Collaborative meeting for the identified resident and presented to unit staff, it stated that when providing care a specified number of staff were to be present.

A review of progress note documentation identified a note which related to a meeting which took place several days earlier. The note provided clear direction with respect to care interventions for the resident.

In an interview with the DOC they said there was confusion in the plan of care. The DOC said that there was a gap when communicating interventions from the meeting to the staff providing care.

The licensee failed to ensure that there was a written plan of care for the residents that set out clear direction to staff and others who provided direct care to the resident.
(568)

4. 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. s. 6. (7)

The plan of care for a resident identified that the resident was a risk for falls. Interventions were in place to mitigate the risk of falls.

A CIS report stated that the resident sustained a fall and was found beside their bed on a specified date. On assessment the resident exhibited signs of injury.

In an interview with a PSW they said that on the evening of the incident they remembered that there was a new staff member orienting on their unit. They recalled that the new staff member had put the resident to bed. When a co-worker found the resident on the floor they noted that one of the interventions identified to mitigate the risk of falls / injury had not been in place at the time of the fall.

The home's investigation report signed by the DOC and in an interview with the DOC they acknowledged that the plan of care for the resident was not followed with respect to falls and injury prevention.

The licensee failed to ensure that the care set out in the plan of care for the resident with respect to falls was provided as per the plan.

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 2, pattern. The home had a level 4 history with ongoing non-compliance with this section of the LTCHA which included:
Voluntary plan of correction (VPC) LTCHA, s. 6. (7) issued January 9, 2018 (2017_610633_0023)
VPC issued September 28, 2016, LTCHA, s. 6. (7) (2016_260521_0039)
VPC issued July 21, 2016, LTCHA s. 6. (7), s. 6. (11) (b) (2016_303563_0020)

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 22, 2019(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

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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)

Linked to Existing Order / Lien vers ordre existant: 2017_610633_0023, CO #005;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 23. (2) A licensee shall report to the Director the results of every investigation undertaken under clause (1) (a), and every action taken under clause (1) (b). 2007, c. 8, s. 23 (2).

Order / Ordre :

The licensee must be compliant with LTCHA, 2007 S.O. 2007, c. 8, s. 23 (2).

Specifically the licensee shall ensure that:
1) The results of every investigation of alleged, suspected or witnessed incident of abuse of a resident by anyone; neglect of a resident by the licensee or staff; or anything else provided for in the regulations is reported to the Director.
2) The results of the investigation shall include all material that is provided for in the regulations specifically but not limited to O.Reg. 79/10, s. 104 (1)(2)(3).

Grounds / Motifs :

1. The licensee has failed to comply with compliance order #005 from inspection 2017_610633_0023 issued January 9, 2018, with a compliance date of January 30, 2018.

The licensee was ordered to report to the Director the results of every investigation of alleged, suspected or witnessed incident of abuse of a resident by anyone; neglect of a resident by the licensee or staff or; anything else provided for in the regulations; and every action taken in response to every such incident. In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include all material that is provided for in the regulations specifically but not limited to O.Reg. 79/10, s.104 (1)(2)(3) that states that the licensee shall include the following material in writing:

(1) A description of the incident, including the type of incident, the area or location of the incident, the date and time of the incident and the events leading up to the incident.
(2) A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
(3) Actions taken in response to the incident, including,
i. what care was given or action taken as a result of the incident, and by whom,
ii. whether a physician or registered nurse in the extended class was contacted,
iii. what other authorities were contacted about the incident, if any,
iv. whether a family member, person of importance or a substitute decisionmaker of any resident involved in the incident was contacted and the name of such person or persons, and
v. the outcome or current status of the individual or individuals who were involved in the incident.
(4) Analysis and follow-up action, including,
i. the immediate actions that have been taken to prevent recurrence, and
ii. the long-term actions planned to correct the situation and prevent recurrence.
(5) The name and title of the person making the report to the Director, the date of the report and whether an inspector has been contacted and, if so, the date of the contact and the name of the inspector.

The licensee reported the results of investigations to the Director, but failed to include all material that is provided for in the regulations specifically but not limited to O.Reg. 79/10, s.104 (1)(2)(3).

a) A CIS report was submitted to the MOHLTC which stated that an email was sent to the DOC regarding several residents that were not provided continence care. Three residents were identified in the CIS report. The staff who discovered the incident were identified but the only mention of the staff member involved was their first and last initials.

The DOC said they became aware of two other residents who were involved in the incident during their investigation but had not updated the CIS report with their names. In addition, the DOC stated that they had not notified those residents' substitute decision makers (SDMs) of the alleged incident of neglect and they had

not pursued an investigation of those residents. With respect to the full names of staff involved in the incident not being included on the CIS report, the DOC was unaware that this was required.

The licensee failed to ensure that the names of all residents, notification of all SDMs and full names of all staff involved in the alleged incident of neglect / incompetent care were reported to the Director.

b) The home submitted a CIS report for an incident of alleged abuse of a resident.

Review of the home's investigation notes did not provide information in relation to follow-up action including long term actions to prevent the situation from occurring again. The notes did not indicate that the outcome of the investigation was discussed with the resident's SDM.

During an interview with the SDM they recalled meeting with Administrator and Dietary Manager in the initial stages of the investigation but they could not recall any subsequent meetings.

The Administrator and Dietary Manager shared that they remembered having a follow-up meeting with the SDM but there was no record of it.

The licensee failed to report to the Director the analysis and follow-up action including the long-term actions planned to correct the situation and prevent recurrence.

c) The home submitted a CIS report in relation to an incident of alleged abuse. In a review of the home's investigation notes and during an interview with a PSW it was verified that a resident reported concerns of alleged abuse by a specific PSW to a RPN.

The DOC shared that the CIS report did not include the name of the PSW that was present at the incident.

The licensee failed to ensure that the report to the Director included the names of any staff members present at the incident.

d) A CIS report was submitted to the MOHLTC for an incident of alleged staff to resident verbal abuse. The resident identified the three staff involved in the incident but their names were not included on the CIS report.

In an interview with the DOC they said that their investigation included interviews with the staff accused of verbally abusing the resident, but missed those staff names on the CIS report.

The licensee failed to ensure that CIS report to the Director included the names of all staff members involved in the incident.

The severity of this issue was determined to be a level two as there was potential/ risk of harm. The scope was isolated, affecting two out of eighteen residents reviewed. The home had a level 5 history with multiple non-compliances and at least one related compliance order to the current area of concern:
Compliance order #005 issued January 9, 2018, with a compliance date of January 30, 3018 (2017_610633_0023)

(568)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 03, 2019

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:

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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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)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

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

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

Issued on this 24th day of December, 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by MARIA MCGILL (728) - (A1)

Ontario

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