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

Central West Service Area Office
1st Floor, 609 Kumpf Drive
WATERLOO ON N2V 1K8
Telephone: (888) 432-7901
Facsimile: (519) 885-2015

Bureau régional de services de Centre Ouest
1e étage, 609 rue Kumpf
WATERLOO ON N2V 1K8
Téléphone: (888) 432-7901
Télécopieur: (519) 885-2015

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
Oct 24, 2019	2019_610633_0005 (A2)	026972-18, 029984-18, 029985-18, 030552-18, 030671-18, 032410-18, 032465-18, 033050-18, 033051-18, 033052-18, 033053-18, 033054-18, 033055-18, 033763-18, 000531-19, 000996-19, 001198-19, 001537-19, 003044-19, 004107-19, 005399-19, 005673-19, 005849-19, 005965-19, 006024-19	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 SHERRI COOK (633) - (A2)

Ontario

Ministry of Health and Long-Term Care

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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*

Amended Inspection Summary/Résumé de l'inspection modifié

CO #006 CDD extension to December 16, 2019.

Issued on this 24th day of October, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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

Amended by SHERRI COOK (633) - (A2)

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): March 26-29, April 1-5, 15-18, 23-26, 29-30, May 1-3, 2019.

The following intakes were completed during this inspection:

Log #029984-18- Follow up (FU) to compliance order (CO) #001 related to safe and secure home.

Log #029985-18- FU to CO #002 related to College of Nurses (CNO) registrations.

Log #033052-18- FU to CO #003 related to sufficient staffing.

Log #032410-18- FU to CO #004 related to skin and wound.

Log #'s 033053-18, 033051-18, 033050-18 and 033055-18- FU to CO's #001, #002, #005 and #007 related to abuse.

Log #033054-18- FU to CO #006 related to plan of care.

Log #026972-18- Complaint related to medication administration and reporting to the Director.

Log #'s 030671-18, 000531-19 and 001537-19- Complaints related to resident care, staff shortages and 24/7 RN.

Log #030552-18- Complaint related to admissions.

Log #006024-19- Complaint related to skin and wound and responsive behaviours.

Log #'s 033763-18, 001198-19 and 003044-19- critical incidents (CIs) related to falls prevention.

Log #'s 005673-19, 032465-18, 000996-19, 004107-19, 005399-19 and 005849- CIs related to alleged abuse.

Log # 005965- CI related to an unexpected death.

During the course of the inspection, the inspector(s) spoke with the Director of Health Services (DHS), the Administrator, the Acting Director of Care (A-DOC), a Nurse Consultant/ Director of Care (NC/DOC), the Dietary Services Manager (DSM), the Environmental Services Manager (ESM), the Human Resources Management Coordinator (HR-MC), the Human Resources Specialist (HR-S), the Human Resources Generalist (HR-G), the Administrative Supervisor (AS), the Supervisor Scheduling (SS), the Recreational Manager (RM), a Physician, a Pharmacist, a Dietitian, the Resident Assessment Instrument Coordinator (RAI-C), Registered Nurses (RNs), Registered Practical Nurses (RPNs), a Behaviour Support Ontario Registered Practical Nurse (BSO-RPN), Personal Support Workers (PSWs), Dietary Aides (DAs), a Nursing Student (NS), a Food Service Worker (FSW), housekeepers, family members and residents. In addition, the inspector spoke with the South West Local Health Integration Network Patient

Care Manager (SW-LHIN PCM), a SW-LHIN Manager, and a Grey Bruce Resource Team Behaviour Support Ontario team member (GBRT).

The inspector(s) also conducted tours of the home and made observations of resident care, resident/staff interactions, dining and snack service, medication administration and maintenance. A record review of the clinical records of the identified residents was completed including resident assessments and plans of care. The home's relevant policies and procedures and related documentation were also reviewed.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Hospitalization and Change in Condition
Medication
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing
Training and Orientation

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

- **31 WN(s)**
- **9 VPC(s)**
- **18 CO(s)**
- **5 DR(s)**
- **0 WAO(s)**

The following previously issued Order(s) were found to be in compliance at the time of this inspection:
Les Ordre(s) suivants émis antérieurement ont été trouvés en conformité lors de cette inspection:

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 46.	CO #002	2018_580568_0016	633
LTCHA, 2007 S.O. 2007, c.8 s. 5.	CO #001	2018_580568_0016	659

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Findings/Faits saillants :

The licensee has failed to ensure that at least one registered nurse was on duty and present in the home at all times.

Two complaints received by the Ministry of Health and Long-Term Care (MOHLTC) were related to a 24/7 registered nurse (RN) not working at the home.

Two Human Resources (HR) reports for a specific time period documented that there was no RN working at the home for five full shifts and two partial shifts.

Three registered staff all said that there was not always a RN working on every shift. The Administrator agreed that 24/7 RN was required and they recalled a few times where there was no registered nurse working.

The licensee failed to ensure that there was a RN working and present at the home for five full shifts and two partial shifts during a specific time period.

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with 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 :

This inspection was completed as Follow Up (FU) to compliance order (CO) #002 from #2018_580568_0014 related to reporting to the Director immediately.

The home's compliance action plan was not implemented and stated that after immediately being informed of any alleged suspected or witnessed incident of abuse or neglect of a resident the Administrator would ensure a critical incident report (CI) was submitted to the Director within the required timelines.

A) Two incidents of alleged abuse/improper care of a resident were not reported immediately to the Director as required.

i) A CI was submitted to the MOHLTC which stated that an identified resident had reported to the Acting DOC (A-DOC) that they had been inappropriately touched.

A progress note stated the date of the incident. The home did not submit the allegation of abuse to the Director until six days later. The after-hour pager was not called. The progress notes also stated that the resident continued to voice concerns related to the allegation to different staff members after the incident occurred. The Administrator and A-DOC both confirmed that the incident of alleged abuse was not reported immediately to the Director as required.

ii) A registered staff member said that an identified resident sustained an injury during a transfer by staff on a specific date. The staff member also said they had told the previous Director of Care (DOC) that a CI report should be submitted to the MOHLTC. The incident should be investigated related to the improper care and transfer of the resident. The staff member and the progress notes both stated that the resident's condition declined after this incident.

The home's CI reports did not include a CI to the MOHLTC related to this incident. The Administrator confirmed that a CI was not submitted to the Director as required.

Two incidents of alleged abuse/improper care were not reported immediately to the Director as required.

Additional Required Actions:

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

DR # 002 – The above written notification is also being referred to the Director for further action by the Director.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Findings/Faits saillants :

This inspection was completed as FU to CO #002 from inspection 2018_580568_0016 issued October 26, 2018. The compliance due date was January 21, 2019. CO #002 stated:

O.Reg 79/10, s. 46. states that every licensee of a long-term care home shall ensure that every member of the staff who performs duties in the capacity of registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario.

The licensee must be compliant with O. Reg 79/10, s. 46.

Specifically, the licensee must:

1. Develop and implement a process that identifies who will be responsible for ensuring that every member of the staff who performs duties in the capacity of a

registered nurse, registered practical nurse or registered nurse in the extended class has the appropriate current certificate of registration with the College of Nurses of Ontario.

2. That the licensee ensure that this check is done before the employee performs any of their duties in the capacity of a registered nurse, registered practical nurse or registered nurse in the extended class and that there is documentation kept in the home which identifies who completed the check and the date the check was completed.

The licensee was compliant with O. Reg 79/10, s. 46 however, the home was not compliant with CO #002. The licensee failed to implement a process at the home that identified who completed the College of Nurses (CNO) registration checks and who would be responsible for maintaining the documentation at the home.

The Administrator stated that County Human Resources (HR) completed the CNO checks for new hires and they were unsure if they could access this information. CNO checks for registered employees were completed by the home annually thereafter. The Administrator stated that the CNO checks were located in the personnel files at the home for each staff member. They said the previous DOC completed this task and the current A-DOC could help with the Inspectors review of the documentation.

The A-DOC stated that the CNO checks were contained in the employee files at the home and they randomly selected the employee files for three registered staff members. The three files were reviewed with the A-DOC and two of three CNO checks were not present. The Administrator later reviewed the three identified files and agreed that two CNO checks were not present in the employee files.

On a later date, the Administrator said that the CNO checks were now present and explained that each employee had two files at the home. They also said that someone at the home had previously provided the inspector the HR files located off-site and not the files located at the home. The Administrator randomly selected a fourth employee file of a registered staff member and their CNO check was not present. The Administrator then said that the Administrative Assistant (AA) was away for the next week and they had the CNO checks in another cabinet and were likely too busy to file them.

The Administrative Supervisor (AS) later provided two green binders and stated

that these contained the remaining CNO checks. Two of four previously reviewed CNO checks for registered staff members were not present. There was no documentation as to who had completed the checks.

The licensee has failed to implement a process at the home that identified who completed the CNO checks and maintained the documentation at the home.

2. The licensee has failed to comply with the The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN). The LSSA stated that the licensee was required to meet the practice requirements of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) system. Each resident's care and service needs would be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team and the licensee would also ensure that RAI-MDS tools were used correctly to produce an accurate assessment of the Health Care Service Provider's (HSP) residents. Resident Assessment Protocol's (RAPs) were to be generated, reviewed and completed for triggered RAPs and non-triggered clinical conditions within seven days maximum of the Assessment Reference Date (ARD) (RAI-MDS Data – 8.1(c)(ii)).

Brucelea Haven has 144 beds however, at the time of the inspection their were 134 residents residing at the home.

An email from the previous DOC to the Resident Assessment Instrument Coordinator (RAI-C) identified concerns related to the outstanding RAI-MDS assessments as this compromised resident care and resident care plans would not be accurate. During a specific period, there were 43 RAI-MDS assessments that were past their ARD and required completion.

The Clinical MDS portal reports documented the current outstanding RAI-MDS assessments by resident home area (RHA). During a specific period, there were 42 RAI-MDS assessments that were past their ARD. The RAI-C confirmed that the RAI-MDS assessments were past their ARD.

A three resident sample in PCC was also completed related to RAI-MDS assessments past their ARD during a specific time period. They ranged from 13 to 40 days past their ARD. The records showed that the resident's RAPs and care plan updates had not been completed.

The RAI-C provided an updated MDS report which documented that 26 RAI-MDS assessments were still past their ARD. When asked what the impact and risk of uncompleted RAI-MDS assessments for the resident was, the RAI-C stated assessments would not be completed and individualized care plans would not be up to date. The risk also included the home missing key care areas.

The licensee did not comply with the conditions to which the licensee was subject. Specifically, the LSSA with the LHIN, under the Local Health Systems Integration Act, 2006, which required the licensee to meet the practice requirements of the RAI-MDS.

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a process is implemented that identifies who will be responsible for ensuring CNO checks are completed, and who will complete the check and maintain the documentation at the home, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Three of the home's policies were not complied with and two of the home's policies were not in compliance with all applicable requirements under the Act.

A) In accordance with O. Reg. 79/10, s. 48(1) and in reference to s. 49(1), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's falls prevention policy that stated that as part of their falls prevention and management policy staff were required to conduct a Head Injury Routine (HIR) for each unwitnessed fall as a strategy for monitoring residents post fall. Staff were directed to monitor HIR as per the schedule on the form for signs of neurological changes (i.e. facial droop, behavioural changes, weakness on one side, etc).

A dated progress note stated that an identified resident was found lying on the floor. An injury was noted and the resident was unable to state if they had hit their head.

The RAI-C stated that the HIR was to be initiated as the residents fall was unwitnessed however, they were unable to locate the paper HIR form in the resident's chart. The RAI-C stated that the HIR was not initiated for the identified resident's fall on a specific date.

The licensee has failed to ensure the the home's HIR strategy to monitor a resident post fall was followed.

B) In accordance with O. Reg. 79/10, s. 135(2) and in reference to s.115(1) the licensee was required to review, analyze and document all medication incidents to identify changes to improve the medication management system.

Specifically, the home was non-compliant with the home's medication incident management policy. The AS confirmed the home's current policy in use related to medication incidents. The policy stated that the DOC was to review the incident and conduct and document an investigation to determine the root cause, contributing factors and corrective and preventative actions.

i) A medication incident report (MIR) stated that an identified resident received a medication without an order. This medication had been discontinued.

A registered practical nurse (RPN) reviewed the plan of care for the resident and the MIR. Medication orders were usually processed on days and the medication should have been removed from the medication cart when the medication was discontinued on the day shift.

ii) Another MIR stated that an identified resident received the wrong dose of a specific medication.

Both MIRs did not include any documentation that an investigation and staff interviews had been completed.

The A-DOC reviewed one MIR and said they were involved with this medication incident. The A-DOC acknowledged that they did not interview staff or investigate. The Pharmacist reviewed both medication incidents and agreed that an investigation was not documented online on the MIR system related to one MIR. They said that both incidents lacked detail and documentation. The AS was unable to locate any further documentation that had been completed by the DOC or delegate related to an investigation into either medication incident.

The licensee was non-compliant with the home's medication incident management policy that directed the DOC or designate to investigate, interview staff, and maintain documentation related to the investigation to identify root causes and contributing factors to prevent recurrence and reduce risk.

C) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have instituted or otherwise put in place any policy, that the policy was in compliance with all applicable requirements under the Act and complied with.

Two of the home's policies were not in compliance with all applicable requirements under the Act.

1) In accordance with O. Reg. 79/10 s. 50 (2)(b)(i)(iv), the licensee was required to ensure that a resident at risk of 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 and altered skin integrity and was reassessed weekly when clinically indicated.

The AS provided the home's skin and wound policy and on a different date a RPN provided a different skin and wound policy. The RAI-C confirmed the correct policy. The policy directed registered staff to conduct weekly wound and skin care rounds, assess for pressure wounds stage II or greater and wounds with other etiologies.

A dated e-mail was sent to registered staff at the home that directed staff that weekly wound assessments for stage I pressure ulcers was not required. The home's documentation related to their skin and wound program included documentation which described a stage I pressure injury.

Four registered staff members were interviewed and they had different processes to manage stage I pressure ulcers. Their stated process also differed from the direction in the home's skin and wound policy.

2) In accordance with O. Reg. 79/10, s. 116(3) and in reference to s.115, the licensee was required to have a system in place to review the quarterly medication management evaluations and medication incidents from the previous year annually.

Specifically, the home's medication incident management policy did not include a process to review the quarterly medication incidents from the previous year.

The home's medication management evaluation did not specify that the annual evaluation would include a review of the quarterly evaluations in the previous year as referred to in s. 115, using an assessment instrument designed specifically for this purpose.

The AS said that medication incidents were reviewed at the Professional Advisory Committee (PAC) meetings.

The home's annual medication management evaluation and assessment tool and dated PAC meeting minutes did not include a review of the quarterly medication incidents from the previous year. The Pharmacist said they met with the previous DOC informally on several different days to complete the annual medication management evaluation. A detailed review was not completed.

The home's Falls Prevention and Management, Medication Incident Management and Skin and Wound Care Management Program policies were not complied with and the home's Skin and Wound Care Management Program and Medication Incident Management policies were not in compliance with all applicable requirements under the Act.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with 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 :

This inspection was completed as FU to CO #005 from #2018_580568_0014 related to duty to protect.

The licensee has failed to protect an identified resident from neglect. There was a pattern of unsafe transferring techniques at the home and staff not following the resident's assessed safety needs and care plan related to their transfer status.

O. Reg. 79/10, s. 5. defined neglect as the failure to provide a resident with the care, services or assistance required for their health, safety or well-being, and included a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A) Three unsafe transfers of an identified resident by staff occurred which resulted in injuries.

i) A RPN said that the resident sustained an injury related to a transfer and the resident's health had declined since then.

A dated report stated that the resident was transferred using the extensive assistance of one person twice on the date that the incident occurred. It was also documented that the resident was transferred multiple times using one person assistance during a specific month. However, the resident's plan of care stated that the resident required a two person physical assist for transfers.

The RAI-C said that the resident required two staff members to physically assist them for their transfers at the time this incident occurred. They also said that the resident was not transferred safely by the identified PSW which resulted in an injury.

ii) Two CI's were submitted to the MOHLTC related to the same resident. The CI's documented a transfer by staff that had resulted in injuries.

One CI documented that the resident was transferred with one person and the resident's plan of care stated that they required a one person transfer. However, the resident's care plan documented that their transfer status was changed to two person physical assist and they required two staff assistance for their transfers at the time of the incident.

The home's investigative notes, POC, and the identified PSW stated that they had transferred the resident alone. The RAI-C said that the plan of care stated that the resident required two staff members for transferring. The resident sustained an injury.

iii) The second CI documented that a PSW found the resident with an injury.

The resident's plan of care related to their transfer status stated they required total care of two staff members as the resident was unable to assist.

At the time of the incident, the identified PSW had expressed that they would prefer to lift the resident themselves. However, they did not remember the resident having an injury or this incident.

A PSW said that care staff were completing transfers and using lifts incorrectly when working short staffed however, this also occurred when the home was not short staffed. They also said that residents that required two staff for their transfer per their plan of care were being transferred with one staff member.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques per the resident's assessed safety needs when assisting an identified resident with their transfers. The pattern of not following the resident's plan of care related to their transfer status resulted in repeated injuries to the resident.

B) The licensee failed to protect an identified resident from abuse.

O. Reg 79/10 s. 2(1) defined physical abuse as the use of physical force by a resident that caused physical injury to another resident.

A CI report was submitted to the MOHLTC which documented an altercation that had occurred between two residents. One resident sustained an injury.

A complaint was received by the MOHLTC related to a concern for the resident's safety.

The care plan for the identified resident included specific responsive behaviours.

A RN stated that as a result of the altercation, one resident was injured and required treatment. The progress notes documented that the resident was emotionally upset after this incident occurred.

Three staff all said that abuse included physical and emotional.

The licensee failed to protect an identified resident from abuse by another resident on a specific date.

C) The licensee failed to protect an identified resident from neglect by staff.

A CI was submitted to the MOHLTC which stated that an identified resident fell and sustained an injury.

A dated risk management report and progress note documented that the resident was found on the floor. The resident had injuries and complained of pain.

The home's investigation notes stated that a RPN left the resident unattended despite being aware that the resident was at risk of falling. The registered staff also did not follow-up with the resident's pain when the resident was calling out in pain.

A staff member reported that they were working when the incident occurred and they had noted the resident at risk of falling and calling out in pain. They said that more could have been done to prevent the fall from occurring and the nursing staff had neglected the necessary care for the resident to prevent their fall.

The identified RPN said that when they repositioned the resident, the resident screamed in pain and leaned forward right after. The RPN also stated that they left the floor and did not communicate with staff that they were leaving the unit. PSWs were in resident rooms checking on other residents. The RPN acknowledged that they left the unit while the resident was crying out in pain. They agreed that the resident was left at risk.

The Administrator said that the home's investigation revealed that staff had left the resident unattended crying out in pain. The resident fell and sustained an injury as a result.

The licensee failed to protect an identified resident from neglect by staff on a

specific date.

Additional Required Actions:

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 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 :

This inspection was completed as FU to CO #003 from inspection 2018_580568_0014 related to the home's staffing mix.

1) The home's staffing plan was not implemented, and staffing shortages and lack of leadership supports impacted resident care in multiple care areas.

A) The Administrator provided a copy of the home's annual evaluation of the staffing plan which included the required daily staffing complement for the home.

B) The HR reports during a specific time period showed that multiple nursing staff worked overtime. The HR-S confirmed the overtime hours worked. Despite the overtime by all disciplines, the home was unable to maintain their staffing plan levels for RNs, RPNs and PSWs. Three RPNs and three PSWs said that there was a strain on staff and overtime and doubles were worked constantly.

C) The HR reports also showed that the home did not have the full complement of PSW staff despite the overtime worked by PSWs daily. The HR-S confirmed the PSW hours worked. The Administrator agreed that the home was short PSWs during the identified time period and they acknowledged that staff were working overtime.

D) A HR report identified the home's staffing vacancies. There were no full-time positions being recruited. The job postings online and related documentation provided by HR showed that advertising was not completed as outlined in the home's recruitment plan.

2) The staffing shortages impacted resident care in multiple areas:

A) Transfers;

i) Two residents were transferred by one staff when the plan of care directed that the resident required two-person physical assistance. Three improper transfers resulted in significant injuries to one resident.

ii) A staff member was observed using a mechanical lift independently to transfer a resident. The staff acknowledged completing the transfer without assistance and stated most of the PSWs on the unit did not do two-person transfers. When asked why, they said it was a very heavy floor with a lot of residents who needed a transfer with a mechanical lift. Often, they worked short. A PSW said that this placed the residents at risk for falls and injuries. Two staff both said that it was difficult to get assistance to provide care to residents. Two RPNs said there were times when there was one PSW and themselves running the unit. Transfers were

difficult to get done.

Two staff and the A-DOC said that the impact to residents when they worked short was that staff tried to complete all of the transfers at once. One PSW explained that they needed to get residents transferred and into bed right after supper or the RPN and the one PSW would be left to do this in the evening. The A-DOC said one-person transfers occurred because of the lack of staff at the home.

B) Twice weekly bathing according to preference;

A complaint was received by the MOHLTC related to missed bathing at the home.

i) Record review of the plan of care for four current residents and staff interviews were completed related to bathing. Four of four residents did not receive their baths twice weekly. Four staff all said that bath shifts were pulled to the floor and resident baths did not get done. Five staff all said baths may be missed if there was not enough staff to do the baths. When asked if the home's staffing plan allowed for staff to meet the bathing care needs of the residents staff said no. If the home was short, the PSW struggled to get all the residents up or back into bed and there was no time for bathing. The A-DOC acknowledged that bathing was missed and agreed that bathing was not the priority when working short staffed.

ii) The staff schedules showed that the home did not have the PSW shifts filled that were dedicated to bathing during a specific time period.

C) Toileting routines;

Record review of the plan of care for three residents and staff interviews were completed related to toileting. Three of three residents did not receive toileting/continence care per their assessed needs and plan of care. Multiple PSWs stated that continence care was difficult to get done when the home was short staffed.

D) Repositioning and monitoring;

Record review of the plan of care for three residents and staff interviews were

completed related to repositioning. Three of three residents were not repositioned as per their assessed needs and care plan. Multiple PSWs stated that all residents were not repositioned every two hours as there were not enough staff at the home. There were many competing care priorities and some areas of the home had a heavier workload then others.

E) Oral care;

Observations, record review of the plan of care for four residents, and resident and staff interviews were completed related to oral care. Four of four residents did not receive oral care twice daily before breakfast and before their bed time as required. Three PSWs all said that oral care should be completed twice daily before breakfast and bed time and this was not done because of the staffing shortages at the home. Another PSW stated that oral care was provided in the afternoon to help the evening staff out when short staffed. However, two PSWs both said that oral care was signed off as provided when it was not.

F) Assistance at all meals;

Observations indicated that seven residents did not receive the assistance they required for meals. Meals were rushed and there was not enough staff to ensure that one staff assisted only two residents at a time. A PSW said that even when the home was not short staffed, it was difficult to feed all the residents.

A PSW said that when the home was short an RPN and they had to work two units, the RPN was unable to assist in the dining room for meals. When asked what the impact of working short had on feeding, the PSW said that residents did not get a full meal. Another PSW explained that residents who were not cognitively aware were impacted the most. They did not receive the assistance and time they required to eat. The meal was often cold by the time it was served. The PSW explained that residents fell asleep waiting and therefore did not eat or drink as well. A RPN said that they relied on family for feeding residents at meals.

G) Timely medication administration;

Observations, record review of the plan of care for three residents, the home's related documentation, and staff interviews were completed related to timely medication administration. Three of three residents received their time sensitive

medications late and not as prescribed. Four RPNs and the RAI-C all said that when working short they had 48 residents to give medications to, residents had to wait, and medications were late. They also said that the risk of medication errors increased when working short staffed.

H) Completion of MDS assessments;

Staff interviews, RAI-MDS assessments for three identified residents and the home's related MDS reports showed that the RAI-MDS assessments were not completed per the Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN). The completion of RAI-MDS assessments was impacted by insufficient front line and leadership staffing. RAPS and resident care plans were not up to date.

I) Assessments for altered skin integrity;

Record review of the plan of care for three residents and staff interviews were completed related to the completion of weekly skin assessments. Three of three residents did not receive weekly skin assessments as required. A RPN said that staffing played a role in wound assessments and whether they were done. They explained that with the resident workload there was no time for paperwork. Another RPN said that wound treatments, wound care and dressings were missed when working short.

J) The RAI-C and the home's related documentation showed that documentation was not completed for two types of meetings which discussed the residents' plans of care. The RAI-C said that this was due to staff not having enough time, and the staffing shortages at the home.

K) Two residents were denied admission to the home and one resident was denied returning to the home. The reason provided was related to the lack of staff at the home that was required to provide the care the residents needed. The family of one resident, a BSO-RPN, the A-DOC and the Administrator all confirmed that this occurred due to the insufficient staffing at the home.

3) The licensee has failed to ensure that the home's staffing plan mix promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to an identified resident.

A) On a specific date an identified resident had specific symptoms.

Two registered staff stated that they noted that the resident had specific symptoms. One RN indicated that they were not familiar with the resident. They did not consider any other etiologies/causes for the resident's symptoms. They were advised to get specific orders. The RN explained that they were unsure how to proceed as they had not been trained by the home related to a specific treatment and orders. Another RN had not been provided orientation and had worked the floor by themselves. Two RNs indicated that they were not familiar with the resident. The RN said they had not worked this floor and their actions were based on the previous night nurses report. A medication error occurred. The RN also said that the home was short registered staff.

The substitute decision maker (SDM) indicated that they were not provided the opportunity to have input into the treatment plan.

The RAI-C explained that the two RNs involved with this incident were new to the home and they had not received their orientation. The A-DOC acknowledged that the home was short staffed when the incident occurred.

B) There were unclear and incomplete standing orders related to a specific treatment.

C) The centralized scheduling system and staff shortages did not promote the continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident. Call outs for shifts were by designation and did not include the RHA.

A PSW said when they worked, and there were call ins to another unit, they pulled them to work that unit. Two RPNs said they were placed wherever there was a hole, and this may not be their home unit. Two staff said that staffing at the home was not better and there was not enough staff. Two staff both said they were called constantly to pick up shifts and staff were switched around on the units last minute. Four staff all said that the home's staffing system lacked continuity in providing resident care as staff were not familiar with the residents. The scheduling supervisor (SS) said that covering shifts was constant and there was not enough staff to cover the required shifts at the home.

4) The PCC dashboard documented staff shortages during a specific time period.

5) Leadership supports;

A) Observations and staff interviews showed that management and HR all worked daytime hours Monday to Friday. The registered staff were responsible for covering the multiple daily staff shortages after-hours on evenings and weekends which impacted the time available for resident care. At times, the registered staff were also managing staffing shortages on days.

B) Observations, staff interviews, and HR reports showed that the home lacked senior nursing supports. The Administrator said that the primary concern was that there were no senior staff at the home.

C) HR reports and staff interviews showed that the A-DOC was not always present at the home in their capacity as A-DOC. They also worked floor shifts to ensure that there was 24/7 RN coverage. There was not always a RN working at the home.

Several staff explained that because of the home's compliance problems, there were more and more duties put on the charge nurses which was difficult with the chronic staff shortages at the home. They also said the way management dealt with their compliance problems was not effective.

6) The home's compliance action plan and annual evaluation of the staffing plan were not implemented.

The plan of care for identified residents, the home's related documentation, multiple staff of all disciplines at the home, the SS, the A-DOC and the Administrator all said that the home's current staffing mix and staffing shortages did not promote continuity of care and did not ensure that there were enough direct care staff/hours to meet the residents' assessed care and safety needs. This included leadership supports, transfers, twice weekly bathing, toileting routines, repositioning and monitoring, oral care, assistance at all meals, timely medication administration, completion of MDS assessments and weekly assessments for altered skin integrity, documentation, admissions/discharge, orientation and palliative care. Further evidence is contained in the compliance orders report.

Additional Required Actions:

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

(A2)
The following order(s) have been amended: CO# 006

DR # 003 – The above written notification is also being referred to the Director for further action by the Director.

WN #7: 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 :

This inspection was completed as FU to CO #001 from inspection #2018_580568_0014 related to alleged abuse investigations.

The home's compliance action plan was not implemented and stated that one lead support investigator would complete the investigation immediately and at the end of the investigation the Administrator would review the file for completeness.

A) Three allegations of abuse/improper care that the licensee knew of were not immediately investigated as required.

i) A CI was submitted to the MOHLTC that stated that an identified resident reported to the A-DOC that they had been inappropriately touched.

A dated progress note stated that the resident reported to the A-DOC that they were inappropriately touched. The resident voiced concerns related to the incident to different staff members for number of days after their initial report.

The home's investigation notes indicated that the Administrator did not initiate the investigation until 20 days after the resident reported the initial allegation to staff. The A-DOC said that the investigation notes from the resident were not received right away as they were not aware of the procedure. The A-DOC and Administrator confirmed that the investigation was not immediately started.

ii) A registered staff member said that they had told the previous DOC that an incident required an investigation as they had concerns related to the improper transfer of the resident by staff.

The Administrator said that because a CI was not submitted related to this incident, an investigation was unlikely to have occurred.

iii) A CI was submitted to the MOHLTC related to an incident that resulted in an injury to an identified resident and a significant change in their status.

A staff member said that they spoke to the Administrator about the incident and their suspicion of improper care/transfer. They said that they had concerns regarding how the resident was transferred that day.

The home's investigative notes did not include an investigation or any other related documentation. The CI did not document that an investigation occurred related to this incident. The Administrator said that the investigative notes related to this incident consisted of the CI report.

The licensee failed to ensure that an investigation was completed immediately related to the allegation of abuse of a resident and when there was a suspicion of improper transfers resulting in injury to another resident.

2. This inspection was completed as FU to CO #007 from inspection #2018_580568_0014 related to reporting alleged abuse investigations to the Director.

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

A CI was submitted to the MOHLTC that stated that a resident had reported that they overheard a PSW yell at another identified resident. The resident had asked the staff to provide them with a specific care. The resident reported that the PSW yelled a comment related to not providing the care.

The home's investigation notes identified that the investigation was initiated however, there were no notes relating to the outcome of the investigation and the CI to the Director was not amended. The A-DOC and Administrator reviewed the CI and said that the CI was not amended and the results of the alleged verbal abuse were not reported to the Director as required.

Additional Required Actions:

CO # - 007, 008 will be served on the licensee. Refer to the "Order(s) of the Inspector".

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

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 44. Authorization for admission to a home

Specifically failed to comply with the following:

s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements; 2007, c. 8, s. 44. (7).
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or 2007, c. 8, s. 44. (7).
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

s. 44. (9) If the licensee withholds approval for admission, the licensee shall give to persons described in subsection (10) a written notice setting out,
(a) the ground or grounds on which the licensee is withholding approval; 2007, c. 8, s. 44. (9).
(b) a detailed explanation of the supporting facts, as they relate both to the home and to the applicant's condition and requirements for care; 2007, c. 8, s. 44. (9).
(c) an explanation of how the supporting facts justify the decision to withhold approval; and 2007, c. 8, s. 44. (9).
(d) contact information for the Director. 2007, c. 8, s. 44. (9).

Findings/Faits saillants :

The licensee has failed to ensure that the home approved two applicant's application for admission to the home.

A complaint was received by the MOHLTC related to the admission refusal of an applicant by the home. The complainant stated that the refusal was related to the

insufficient staffing at the home to provide the required care.

A) The dated refusal letter sent to the applicant and their SDM by the home stated that the reasons for refusal were staffing issues and responsive behaviours.

The South West Local Health Integration Network (SW-LHIN) Patient Care Manager (PCM) reviewed their records and said that at the time of application for admission to the home the applicant's behaviours were managed. The previous DOC had said at the time that there were significant staffing issues to support the applicant in their transition to the home. Supports to assist the applicant's transition were offered but despite the offer, the home refused the applicant's admission. The resident was ultimately placed at another home.

Four staff said they were aware of resident behaviors and they had received training related to responsive behaviours. The home had a secure unit, an internal BSO program and access to internal and external resources related to behaviours. The BSO-RPN stated that BSO shifts had been reduced due to the staff shortages. They said they were called to the floor or BSO just did not get scheduled when the home was working short staffed.

The Administrator said they declined admission to the applicant and this was related to the lack of a social worker at the home and the inability of the home to provide one to one staffing. The Administrator said that their special care unit's primary criterion was residents who were at risk of exit seeking.

B) The dated refusal letter sent to another applicant and their SDM by the home stated staffing issues and a clinically complex case.

A dated written review of the applicant's application was completed by the A-DOC. There were no significant health or behavior issues documented however, the reason for the decline was stated as a clinically complex treatment.

The SW-LHIN PCM reviewed their records and said that at the time of application to the home the applicant no longer required the treatment. The LHIN had questioned the home related to their decline for admission and their reasons. The home later offered the applicant admission however, they refused and were ultimately accepted at another home.

The BSO-RPN said they had a recent resident at the home with this treatment.

The treatment was in the scope of practice for registered staff members. The LHIN would provide supports to the home. The A-DOC agreed that treatment was in the scope of nursing practice and the applicant's admission decline was not related to the staff's lack of knowledge. The A-DOC said that the applicant was declined due to staff shortages at the home and the risk for staff to monitor the treatment when the home was working short. The A-DOC was not aware that the treatment had been discontinued.

The licensee did not lack the physical facilities necessary to meet one applicant's care requirements and staff of the home did not lack the nursing expertise necessary to meet two applicants' care needs. There were no circumstances which were provided for in the regulations for withholding approval for their admissions to the home.

2. A complaint was received by the MOHLTC related to the admission refusal of an applicant. The complainant stated that the reason for refusal was identified as insufficient staffing at the home.

Two written letters withholding approval for admission did not include a detailed explanation of the supporting facts, as they related to both the home and the applicant's condition and requirements for care. An explanation of how the supporting facts justified the home's decision to withhold approval was not included.

The AS and A-DOC reviewed the two refusal letters and agreed that they did not contain a detail explanation with supporting facts as to why the applicants were declined.

The two refusal letters did not meet the requirements of s. 44(9)(b) and s. 44(9)(c), of the LTCHA.

Additional Required Actions:

CO # - 009 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Dated assessments and care plans for four identified residents stated their preferences related to bathing. Four of four residents were not interviewable.

The plan of care for the identified residents showed that they were dependent on staff for bathing and care. All four residents did not receive bathing twice weekly during a specific time period. Four staff agreed that the residents had not had two baths per week as required. The A-DOC agreed that residents should be bathed at least twice a week.

Additional Required Actions:

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

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

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

Findings/Faits saillants :

The licensee has failed to ensure four residents received oral care to maintain the integrity of their oral tissue, including mouth care in the morning and evening.

A) A PSW and the plan of care for an identified resident stated that the resident had most of their natural teeth. The resident was totally dependent on staff assistance for their oral care.

The resident stated they did not receive staff assistance to clean their teeth and for mouth care twice daily.

A dated progress note stated that the resident had a symptom while brushing their teeth. A dated report showed multiple times that oral care was provided after their breakfast meal and in the afternoon before the dinner meal and not in the evening before bedtime as required.

B) The plan of care for another resident stated that they had full upper and lower dentures. The resident was totally dependent on staff assistance for their oral

care.

A dated report showed multiple times that oral care was documented as provided to the resident in the afternoon. Three staff all said that dentures should be cleaned before breakfast and in place for all meals and cleaned at night before bed.

C) The plan of care for another resident stated they were totally dependent on staff for their oral care. Staff were directed on how to provide their oral care.

Two observations showed the resident's oral membranes appeared dry.

Dated reports related to oral care documented three instances when oral care had not been provided twice a day. A PSW acknowledged that oral care had not been provided to the resident. They also said they had documented the oral care as provided for the resident when it was not.

D) The progress notes for another resident documented a family concern related to the resident's dental status.

The plan of care for the resident stated they were totally dependent on staff for their oral care. Staff were directed on how to provide their oral care.

Three observations showed that the oral care had not been provided.

A dated report related to oral care for the resident documented one instance when oral care had not been provided twice a day. On three specific dates PSWs agreed that oral care had not been provided as required. The documentation showed that oral care was provided to the resident when it was not.

Four staff all said that oral care should be provided with morning care and before bedtime. One PSW stated that staff may complete documentation of the care prior to completing the care and that on occasion oral care may be documented as provided when it was not.

The licensee has failed to ensure that four residents received oral care to maintain the integrity of their oral tissue, including mouth care in the morning and evening.

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Findings/Faits saillants :

The licensee has failed to ensure that staff used safe transferring techniques when assisting two residents.

A) A dated assessment stated that an identified resident required two person total assistance for transfers and that their mode of transfer was a mechanical lift. The plan of care stated a mechanical lift was required for transfers for safety.

On a specific date, a PSW was observed to use a lift independently to transfer the resident.

The PSW said that the expectation was that there were two persons to assist when a resident was transferred using a lift.

B) Three transfers of an identified resident were completed by staff that were unsafe and not per the residents assessed care and safety needs.

The plan of care documented that the resident required two person physical assist for transfers and they remained a two person physical assist for their transfers at the time of the incidents.

i) On a specific date the resident was transferred using the extensive assistance

of one staff member twice. Two staff said that the resident sustained an injury and their health had declined since then. The RAI-C confirmed that the resident required two persons for their transfers.

ii) Two CIs were submitted to the MOHLTC related to the same resident that documented two additional transfers which had resulted in injuries.

The home's investigative notes documented that the PSW had transferred the resident themselves.

One CI submitted to the MOHLTC documented that a PSW found the resident with an injury. The PSW had stated at the time that they would prefer to lift the resident themselves. The identified PSW said that they did not remember the incident.

A PSW said that care staff were completing transfers and using lifts incorrectly. They also said that residents who required two staff for their transfer were being transferred with one staff member.

The home's dated transfer policy stated that PSWs would lift and transfer residents according to their plan of care. Mechanical lifts must have two caregivers present during the lifting/transferring or repositioning procedure.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting two residents which resulted in injuries to one resident.

Additional Required Actions:

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

DR # 004 – The above written notification is also being referred to the Director for further action by the Director.

WN #12: 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).
(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).
(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 O. Reg. 79/10, s. 50 (2).
(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).

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown,

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

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

Findings/Faits saillants :

This inspection was completed as FU to CO #004 from inspection #2018_580568_0014 related to skin and wound care.

Two residents identified in CO #004 were no longer at the home and two residents were substituted for them.

A) The plan of care for an identified resident stated that they were totally dependent on staff for all care. The resident had areas of altered skin integrity which required weekly assessments. The skin and wound assessments showed that a weekly assessment was completed on a specific date, and not again until 10 days later.

i) PSW staff were directed to turn and reposition the resident related to their altered skin integrity at specific times. The report dated during a specific period of time documented that the resident was not repositioned as directed.

ii) The resident's plan of care and the home's dated audit report showed that a registered dietitian (RD) referral was not made with the resident`s new and worsening altered skin integrity. The RD referral was not made until a number of

days later, and the RD did not assess the resident until a number of days after.

A PSW said that the resident had areas of altered skin integrity and they required repositioning. Two registered staff said that weekly assessments should have been completed. The RAI-C and the home's related reports stated that the residents wounds had worsened.

B) The plan of care for another resident identified they were at risk for altered skin integrity and they had multiple areas of altered skin integrity.

i) The skin and wound assessments showed that a weekly assessment was completed for three areas on specific dates, and not again until 14 days later. A weekly assessment for another area was completed on a specific date, and not again until 10 days later. A dated progress note did not indicate that one area was healed. As of a specific date, there were no further weekly assessments related to this area of altered skin integrity in the resident's plan of care.

ii) The plan of care for the resident identified that they were totally dependent on two staff for repositioning and they required a specific intervention related to their altered skin integrity.

A PSW agreed that the resident required repositioning every two hours related to their skin sensitivity and altered skin integrity. A dated report showed that the resident was not repositioned as required. The resident`s skin and wound assessments stated that their areas of altered skin integrity had worsened during this time period.

Two registered staff both said that weekly skin assessments should be completed for a resident with altered skin integrity. The RAI-C agreed that the resident should have been assessed weekly and was not.

C) The plan of care for an identified resident stated that they had areas of altered skin integrity.

The skin and wound assessments showed that a weekly assessment was completed on a specific date, and not again until 9 days later. There were no weekly assessments completed on two dates. Three registered staff all said that weekly skin assessments should have been completed.

D) A dated assessments stated a resident was totally dependent on two staff for their repositioning.

The plan of care for the resident documented that staff should turn and reposition the resident every two hours and this included during the night to ensure pressure was relieved. A dated report showed blanks in the documentation.

A PSW stated it should be automatic repositioning every two hours for residents who depended on staff for their mobility and this should be documented. A RPN said that staff should follow the direction in the care plan. The RPN reviewed the documentation for the resident and stated that there were blanks in the documentation which indicated that their repositioning had not been completed.

The licensee has failed to ensure that three residents, who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment tool specifically designed for skin and wound. Three residents were not repositioned per their plan of care and one resident did not receive an assessment by the RD. Two of three resident wounds worsened.

2. CO #004 from inspection #2018_580568_0014 had an amended compliance due date of February 8, 2019. The following is further evidence to support CO #004.

The licensee failed to be compliant with O Reg. 79/10 s. 50(2)(b)(ii)(iv).

A) The licensee has failed to ensure that an identified resident received immediate treatment and interventions to reduce or relieve pain, promote healing and prevent infection.

The substitute decision maker (SDM) for the resident brought forward concerns to the home and the MOHLTC related to the treatment and alleged neglect of the resident.

The resident was admitted to the home with a specific diagnosis. The dated skin and wound assessment stated they had an area of altered skin integrity. Dated progress notes documented that the area worsened and the resident required a specific intervention and treatment.

The resident's SDM and the home's related documentation stated they had requested advanced care for the resident on a specific date.

The request for care was not submitted for the resident until a specific date. The records showed that the care was not provided to the resident until more than one month after the request was submitted by the SDM. A RN acknowledged that there was a delay with respect to the resident receiving their advanced care.

B) The licensee has failed to ensure that an identified resident was reassessed at least weekly by a member of the registered nursing staff when clinically indicated.

A new admission observation tool was completed on a specific date related to the resident`s altered skin integrity. There was no documentation of weekly skin assessments completed until a specific date when the area was documented as worsening. Further weekly assessments were not completed on specific dates and the area progressed. The resident required a specific intervention and treatment.

A RN acknowledged that the resident had an area of altered skin integrity. The RN stated skin and wound assessments were to be completed on admission, return from hospital or leave of absence and quarterly. Two RNs both stated weekly assessments were to be completed if a wound was determined. A RN confirmed that the weekly skin and wound assessments had not been completed for the resident.

The licensee failed to ensure that weekly skin assessments were completed for an identified resident by a member of the registered nursing staff when a resident exhibited altered skin integrity.

Additional Required Actions:

CO # - 013 will be served on the licensee. Refer to the "Order(s) of the Inspector".

DR # 005 – The above written notification is also being referred to the Director for further action by the Director.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

The licensee has failed to ensure that staff did not simultaneously assist more than two residents who needed total assistance with their eating or drinking. Seven residents did not receive their required assistance for meals.

O. Reg. 79/10, s. 73 (7)(8) states that there should be sufficient time for every resident to eat at their own pace and meals were to be served course by course, unless otherwise indicated by the resident or by the resident's assessed needs.

On a specific date, four residents were observed with meals in front of them and there was no staff present to assist them. Staff were assisting more than two residents at a time. None of the residents ate well, fluids remained untouched and they were not offered dessert. Staff and the meal service appeared rushed.

On a specific date, three residents were observed with with their meal in front of them and no staff were present and seated at the table to assist them. Staff were assisting more than two residents at a time.The main meal was served before the residents had finished their first course. Staff and the meal service appeared rushed.

The plan of care for the seven residents stated that they required total staff assistance for their meals.

The home's pleasurable dining rooms procedure was not implemented.

A PSW confirmed that the expectation was that a resident was not served a meal until there was a staff member to assist. Staff should assist no more than two residents at a time.

The licensee has failed to ensure that seven residents received the required assistance for their meals and that staff did not assist more than two residents at a time.

Additional Required Actions:

CO # - 014 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

The licensee has failed to ensure that before discharging a resident alternatives to their discharge had been considered and tried in collaboration with the appropriate placement co-ordinator and other health service organizations. A written notice to the resident and/or the resident`s SDM that outlined the supporting facts as they related to the residents condition and justified the licensee's decision was not provided.

An incident occurred and an identified resident was transferred from the home. Interventions had been identified by an external resource and a specific

recommendation was not made. A dated assessment stated that the resident`s return to the home was anticipated.

The SDMs were told the resident could not return to Brucelea Haven related to staffing shortages. The family was told they needed to provide more care if the resident was to return. A SDM said that they had no support from specific external resources and the home. There was no other solution but to find somewhere else for the resident to go. The SDMs said that they did not receive any written documentation from the home related to the residents condition with supporting facts that justified the home's decision to disallow the resident to return.

A RPN described interventions in place and in progress for the resident. Resources were available and staff had been trained. They acknowledged the family involvement with the resident`s care. They said that the home was short staffed, specific BSO shifts were either not scheduled or they were pulled to the floor to cover shifts. The RPN and the Administrator both stated that a specific intervention was not considered for the resident.

The SW-LHIN PCM said that there was no documentation related to the resident and they were unaware of this incident. They said that a case manager was available to provide assistance however, they were not contacted by the home.

The Administrator and physician both agreed that they told the family that they needed to provide a specific care in order to return to Brucelea Haven. The Administrator denied that they discharged the resident but acknowledged that they told the family the resident could not return to Brucelea Haven. The Administrator stated that they were not aware if the LHIN had been contacted or involved and agreed that no written notice to the family was provided to them by the home.

The licensee has failed to ensure that before discharging an identified resident, alternatives to their discharge had been considered and tried in collaboration with a specific external resource and the LHIN. A written notice to the resident's SDM that outlined the supporting facts was not completed.

Additional Required Actions:

CO # - 015 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A dated medication incident report (MIR) and electronic medication administration record (eMAR) stated that a resident received a medication without an order. The medication had been discontinued. The identified RN gave the medication and did not sign for it. The A-DOC agreed this incident was a medication error and the resident did not receive their medication as prescribed.

B) A dated MIR stated that a resident received the wrong dose of a medication. The RPN had signed that they had given the medication as prescribed however, they had not. The A-DOC reviewed the MIR for the resident and agreed that the resident received the wrong dose.

A drug was administered to two residents that was not in accordance with the directions for use by the prescriber.

C) On a specific date, a RPN was observed working two resident home areas (RHAs) for a total of 48 residents. They said the home was short a RPN and they were administering medications on both units.

i) The physician orders and eMAR for three identified residents stated they had a

specific diagnoses. The residents required a specific medication that was prescribed multiple times a day. The dated medication audit reports showed their medication was given outside of an hour of the prescribed time.

The medication audit report also documented nine additional residents that received their medications over an hour after the prescribed time on this shift on both RHAs. The RPN reviewed the documentation and agreed that these medications were given late when working short.

ii) On a specific date, A RPN was observed administering medication to two RHAs. They said they were working short a RPN.

The dated medication audit report documented that seven residents received an identified time sensitive medication late, not as prescribed and outside of the one-hour time frame.

Two registered staff both said that medications were documented on the eMAR when they were given to the resident.

The RPNs said that although they had an hour before or after the prescribed time to give a medication this was difficult with so many residents. Medication took longer, and residents had to wait. There was also a risk for medication errors and medication incidents when working short. Two RPNs acknowledged the time sensitive medications that were required to control related symptoms. The RPNs and Physician explained that the impact of late medication administration for these specific medications for the resident was potentially increased symptoms. The Physician said that these medications were time sensitive and should be given as soon as possible and/or within the hour of the prescribed time.

The licensee has failed to ensure that drugs, including time sensitive medications to treat specific symptoms, were administered to residents in accordance with the directions for use specified by the prescriber.

Additional Required Actions:

CO # - 016 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #16: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Findings/Faits saillants :

This inspection was completed as FU to CO #006 from inspection #2018_580568_0014 related to plan of care.

Four residents identified in CO #006 were no longer at the home. One resident identified in CO #006 was currently at the home and has been identified in this finding.

The licensee has failed to be compliant with LTCHA, 2007, s. 6 (1)(c), s. 6. (10)(b) and s. 6.(7).

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

A CI was submitted to the MOHLTC which documented a transfer that had resulted in an injury.

The resident care plan documented that their transfer status was two-person transfer however, the CI documented that the resident was a one-person transfer.

The home's investigative notes documented a PSW had transferred the resident alone and that the resident was a one-person transfer. The investigative notes included a printed care plan that was in effect at the time the transfer was completed. The care plan documented the resident`s transfer status as two staff physical assist for all transfers.

The identified PSW said that they knew a resident`s transfer status because of

the logo above the resident's bed. They said that at the time they completed the transfer the logo above the bed indicated that the resident was a one-person transfer and not two staff.

B) The licensee has failed to ensure that a resident`s plan of care was reviewed and revised when the resident's care needs changed.

A dated assessment for an identified resident documented their status related to continence. The care plan had not been updated. A PSW said that they referred to the care plan for continence care and the level of staff assistance a resident required. A RPN reviewed the resident`s plan of care and stated that the care plan had not been updated to reflect the resident`s current continence status.

C) The licensee has failed to ensure that the skin and wound care set out in the plan of care was provided to a resident as specified in their plan of care.

i) The plan of care for a resident identified that they had areas of altered skin integrity which required a specific intervention.

The resident was observed without the intervention on two dates. A PSW said that the resident required the intervention at all times.

A dated progress note stated the resident sustained an injury and the intervention was not in place. A RPN said the intervention should have been in place and was not. They agreed that the resident sustained an injury as a result.

ii) The licensee has failed to ensure that care set out in the plans of care for four residents related to their continence care was provided to the residents as specified in their plans of care.

The assessments and care plans stated that the four residents required specific care and staff assistance. Documentation showed that the residents did not receive the care they required. Four staff confirmed that the care was not provided.

Additional Required Actions:

CO # - 017 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #17: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

The licensee has failed to ensure that all registered staff had received orientation training before performing their responsibilities, including policies of the licensee

that were relevant to the staff's responsibilities, and any other areas provided for in the regulations.

One RN indicated that they had not completed their orientation. A RN said they were unsure how to proceed with specific orders as they had not been trained. Errors were made related to the orders.

Documentation related to orientation shifts and training showed that one RN had not completed their orientation. They were also missing a training day.

The AS confirmed that a RN had missed the clinical training day and had not completed their orientation fully before they were placed on the floor to work on their own.

The A-DOC acknowledged that they were short staffed when the incident occurred and they made the call to have the RN work on the floor by themselves. The A-DOC said that the home should have provided six shifts for new hires, two on each of days, evenings and nights and they did not.

Two written requests were made to the AS by the Inspector to provide a signed copy of the staff passport/checklist that demonstrated that nursing specific orientation related to RN/RPN roles and responsibilities was completed by four registered staff. In addition, a written request was made to inquire about the follow-up process related to orientation. No further response and documentation was provided by the AS or A-DOC.

The RAI-C said both RNs were new to the home and they had not been provided with education related to the specific orders. They acknowledged that the home's orientation checklist included this training. The RAI-C also indicated that the supervisory role at the home for education had not been in place.

2. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in palliative care annually.

During this inspection staff at the home raised concerns about the lack of direction and confusion surrounding palliative care.

When staff education was requested in relation to palliative care, the home did not

provide any training records.

The home's education did not include information on palliative care.

Five registered staff all stated that there had been no training for palliative care provided at the home and they could not remember the last time that any training was done. The A-DOC was asked the last time palliative education was provided at the home and they said that they did not know.

3. The licensee failed to ensure that training in falls prevention and management was provided to all staff who provide direct care to residents.

O. Reg. 79/10, states that training in falls prevention and management shall be provided to all staff who provide direct care to residents.

A) The RAI-C said that the home recently changed their falls risk assessment tools. They said that it was rolled out in pieces through e-mail and staff were confused. They said initially the new assessment was not available in PointClickCare (PCC) and there was no plan on how the training would be tracked to ensure it was completed annually.

A RPN said that they knew very little about the home's falls program. There was a new policy but they had not seen it. They had received an email that indicated a new assessment tool was being used but they were not familiar with it. The RPN said the roll out of the new tool was ineffective and poorly organized.

The A-DOC said that they had been providing education in pieces to staff by e-mail. They said they believed the education provided was effective and that they were available to answer questions.

B) The RAI-C said that new equipment was ordered and that education was not provided to all PSW staff.

A document stated that due to many PSWs not attending the training, the equipment was taken off the floor. Eventually, the manual was placed on the floor for PSWs to read. The RAI-C said that all PSWs did not receive training. The A-DOC said that RAI-C would know what education was provided to the staff.

The home's education did not include the changes to the post fall assessment or

information on how to use the new equipment.

The licensee failed to ensure that staff had been trained when there were changes to the home's falls prevention and management program.

4. The licensee failed to ensure that direct care staff were provided training in skin and wound care.

The home's policy and related documentation stated that registered staff were not required to complete weekly wound and skin care rounds and assess for wounds with other etiologies. Three registered staff all had different understandings of the direction that the skin and wound policy provided.

The home was unable to provide records related to the staff training on skin and wound care. The home's education related to skin and wound did not include the home's policy.

The RAI-C said that the training for registered staff was scheduled but was cancelled. A RPN said that they did not receive training on the skin and wound policy and that their training consisted of what they learned on the job. The Administrator said that training related to the skin and wound program was not completed.

Four staff and the Administrator identified different skin and wound program leads.

The licensee failed to ensure that direct care staff were provided training on the home's skin and wound policy and the skin and wound care processes required in the home.

Additional Required Actions:

CO # - 018 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #18: 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 :

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

A CI was submitted to the MOHLTC related to a resident fall with injury. A staff member alleged neglect and said that more could have been done to prevent the fall.

The home's Prevention of Abuse and Neglect of a resident policy stated if any employee or volunteer witnessed an incident, or has any knowledge of an incident, that constituted resident abuse or neglect, all staff were responsible to immediately inform the Executive Director (ED)/Administrator /DOC and/or charge nurse in the home.

The identified staff member acknowledged that they should have reported the incident to their immediate supervisor immediately and they did not. A Manager confirmed that the staff member did not report the incident immediately.

The licensee failed to ensure that the home's prevention of abuse and neglect policy was complied with related to staff not immediately reporting alleged neglect of a resident to management.

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 home's written policy that promoted zero tolerance of abuse and neglect of residents is complied with, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must 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. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the written record documented the date of the evaluation and identified the date the changes were implemented.

The home's evaluation tool did not contain the date that the skin and wound program evaluation was completed.

Two different versions of the home's actions were provided. The Administrator provided the skin and wound evaluation in which the columns were blank for all identified actions. On a later date, the RAI-C said that the skin and wound committee reviewed the program last year. They said that they met last week to update the status section of the skin and wound program evaluation.

The updated version had documentation in the status column of the report. Three of the actioned items were documented as "not started" in the status section. One of the items stated that the action was unable to be completed due to nursing shortages.

The RAI-C said that the date the skin and wound program evaluation occurred was not documented on the form. They said that the DOC was previously responsible for the program evaluation and that with changes to this role, many of the actioned items were documented as "not started".

The licensee failed to ensure the skin and wound program evaluation documented the date the evaluation was completed and the date the changes were implemented.

2. The licensee failed to ensure that the falls prevention and management program evaluation included the date that the summary of changes were implemented.

The home's dated falls program evaluation tool documented the committee members who participated in the evaluation and two goals and objectives. There were a number of summary changes made/accomplishments listed for both falls and restraints. However, the summary of changes did not include dates that the changes were implemented.

The A-DOC said that the previous DOC took care of the program evaluations. They said that in terms of evaluating the program, they met frequently with other stakeholders to discuss their falls program and the home sent a report to their sister home to see how they were doing in regards to falls prevention and management.

The licensee has failed to ensure that the falls prevention and management program evaluation included the date that the changes that were identified from their falls program evaluation were made and implemented.

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 a written record relating to each evaluation under paragraph 3 includes the date of the evaluation, a summary of the changes made and the date that those changes were implemented, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 69. Weight changes
Every licensee of a long-term care home shall ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status. O. Reg. 79/10, s. 69.

Findings/Faits saillants :

The licensee has failed to ensure that a resident with weight changes of five to ten percent was assessed using an interdisciplinary approach and actions were taken and outcomes evaluated.

The clinical record for an identified resident showed their weight had fluctuated over the course of their time in the home. The resident had documented weight changes of five to ten percent on specific dates. There was no associated interdisciplinary assessment documented with actions taken or outcomes evaluated for each of the instances, with the exception of the weight change which was assessed during the resident's quarterly review.

On a later date, a dietary referral had been made to the Dietitian for altered skin integrity. The Dietitian action and response was a re-weigh not completed. The Dietitian assessments were aligned to the RAI MDS schedule for assessments for this resident.

A RPN stated residents were to be weighed monthly by staff and they did not recall the parameters for re-weighing a resident. They stated there were no parameters around when, how, or who could make a referral to the Dietitian. The RPN said that generally they would make a referral to the Dietitian if a resident had a weight change of two kilograms (kg). They stated that PCC generated an alert for five to ten percent weight loss and if they saw this they would have staff re-weigh the resident to ensure the scale was calibrated appropriately. If the re-weigh was consistent then they would put in a referral to the Dietitian.

The Dietitian stated that they assessed residents who are at high risk for nutritional concerns and they also completed annual assessments for all residents of the home. They said they would normally see the high risk residents quarterly or annually, unless a referral had been made to them.

The licensee has failed to ensure that a resident with weight changes of five to ten percent was assessed using an interdisciplinary approach and actions were taken and outcomes evaluated.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents with the following weight changes are assessed using an interdisciplinary approach, and that actions are taken and outcomes are evaluated:
1. A change of 5 per cent of body weight, or more, over one month.
2. A change of 7.5 per cent of body weight, or more, over three months.
3. A change of 10 per cent of body weight, or more, over 6 months.
4. Any other weight change that compromises the resident's health status, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

The licensee has failed to ensure that the appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence.

A CI was submitted to the MOHLTC that stated that a resident reported to the A-DOC that they had been inappropriately touched. The resident described the alleged person who had touched them.

A dated progress note indicated that the resident had reported to the A-DOC that they were inappropriately touched. A later dated progress note stated that staff had received a call from the police force inquiring about the allegations from the resident regarding alleged sexual abuse. The A-DOC stated that the police force was not called until 16 days after the allegation.

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 appropriate police force was immediately notified of any alleged, suspected, or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

s. 116. (3) The annual evaluation of the medication management system must,
(a) include a review of the quarterly evaluations in the previous year as referred to in section 115; O. Reg. 79/10, s. 116 (3).
(b) be undertaken using an assessment instrument designed specifically for this purpose; and O. Reg. 79/10, s. 116 (3).
(c) identify changes to improve the system in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 116 (3).

Findings/Faits saillants :

The licensee has failed to ensure that the interdisciplinary team which must include the Medical Director, the Administrator and the Dietician met annually to evaluate the effectiveness of the medication management system in the home.

The dated evaluation tool was provided by the AS. They said this was the annual evaluation of the medication management system. They also said that medication incidents were reviewed at the home's PAC meetings. The evaluation did not document that the Medical Director, the Administrator and the Dietitian were present.

Three dated PAC meeting minutes did not document that the Medical Director attended.

The Pharmacist said that they met the previous DOC and reviewed the medication management system. The Pharmacist also said that items that were discussed were done in a piecemeal manner and at different times.

The licensee has failed to ensure that the Medical Director, the Administrator, and a Registered Dietitian were included in the annual evaluation of the the medication management system at the home.

2. The licensee has failed to ensure that the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year.

The home's evaluation tool and dated PAC meeting minutes did not document that a review of the quarterly evaluations, including the quarterly medication incidents from the previous year, had been completed. However, the assessment instrument stated "yes" that this had been done.

Two of the home's medication incident management policies did not include a process for review of the quarterly evaluations in the previous year using an assessment instrument designed specifically for this purpose.

The A-DOC and AS both said that medication incidents were reviewed at the PAC meetings. The Pharmacist said that they met the previous DOC and reviewed the annual medication management system. They said that a high-level review was completed.

The licensee has failed to ensure that the annual evaluation of the medication management system included a review of the quarterly evaluations in the previous year as referred to in s. 115 of O. Reg. s. 79/10 of the LTCHA.

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 interdisciplinary team includes the Medical Director, the Administrator and the Dietician meeting annually to evaluate the effectiveness of the medication management system in the home and the annual evaluation of the medication management system includes a review of the quarterly evaluations in the previous year, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

On a specific date, the medication cart was observed as to be left unlocked at two separate times.

The RN acknowledged that they left the medication cart unsecured and unlocked and the expectation was to lock the cart.

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 drugs are stored in an area or a medication cart that is secured and locked, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (2) In addition to the requirement under clause (1) (a), the licensee shall ensure that,
(a) all medication incidents and adverse drug reactions are documented, reviewed and analyzed; O. Reg. 79/10, s. 135 (2).
(b) corrective action is taken as necessary; and O. Reg. 79/10, s. 135 (2).
(c) a written record is kept of everything required under clauses (a) and (b). O. Reg. 79/10, s. 135 (2).

Findings/Faits saillants :

The licensee has failed to ensure that all medication incidents and adverse drug reactions were documented, reviewed and analyzed, corrective action was taken as necessary, and a written record was kept of everything as required.

A home-specific standing care order set was raised as a concern because staff did not have workable orders. The orders had been under review since last year.

A) On a specific date a medication error occurred related to an identified resident.

The RAI-C said that the revision to the order set had been ongoing and standing care orders were not implemented. A RN acknowledged that the orders were not current.

A review of the orders showed that there were differences. There were two order sets in place for the resident and neither matched. Two registered staff agreed that the wrong orders were in place for the identified resident.

The RN was not aware that a error was made. A registered staff member said they had immediately reported the error to their nurse manger. A medication documentation error occurred. They acknowledged that they did not complete a medication incident report.

The A-DOC said the order set was not up to date, but they had assumed that they were complete. The ADOC said a medication incident report was not completed related this incident.

The Inspector raised this concern with Director of Health Services (DHS) as they were covering for the Administrator, and it was also brought to the attention of both the A- DOC and the Administrator, however, there was no medication incident report completed. This incident was not documented, reviewed and analyzed and no corrective actions were not taken as necessary.

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all medication incidents and adverse drug reactions are documented, reviewed and analyzed, corrective action is taken as necessary, and a written record is kept of everything required under clauses (a) and (b), to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 213. Director of Nursing and Personal Care

Specifically failed to comply with the following:

s. 213. (1) Every licensee of a long-term care home shall ensure that the home's Director of Nursing and Personal Care works regularly in that position on site at the home for the following amount of time per week:
1. In a home with a licensed bed capacity of 19 beds or fewer, at least four hours per week. O. Reg. 79/10, s. 213 (1).
2. In a home with a licensed bed capacity of more than 19 but fewer than 30 beds, at least eight hours per week. O. Reg. 79/10, s. 213 (1).
3. In a home with a licensed bed capacity of more than 29 but fewer than 40 beds, at least 16 hours per week. O. Reg. 79/10, s. 213 (1).
4. In a home with a licensed bed capacity of more than 39 but fewer than 65 beds, at least 24 hours per week. O. Reg. 79/10, s. 213 (1).
5. In a home with a licensed bed capacity of 65 beds or more, at least 35 hours per week. O. Reg. 79/10, s. 213 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home's Director of Nursing and Personal Care worked at least 35 hours per week in their position on site.

Brucelea Haven LTC Home is a 144 bed facility.

On a specific date, the A-DOC left the home for the day. A registered staff member also said that they were aware that the A-DOC would be off for a planned health reason the following week.

The home's HR reports documented that there was no DOC working at the home on nine dates.

The PCC dashboard on a specific date directed staff to call the DOC at the licensee's other home. The A-DOC at Brucelea Haven would not be available until a specific date.

A registered staff member said that staff had been directed to call another DOC that they were unfamiliar with for the home's A-DOC's absence. The Administrator agreed that the DOC was not present and working at the home on the identified dates.

On a specific date the DHS stated that they had sent the A-DOC home as they were required to cover an RN shift. They said they did not have anyone else and were looking to their other home to cover the remaining DOC hours at the home today. There was no notice for staff on the PCC dashboard related to the absence.

The licensee has failed to shall ensure that the home's Director of Nursing and Personal Care worked at least 35 hours per week in their position on site.

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 ensure that the home's Director of Nursing and Personal Care worked at least 35 hours per week in their position on site, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

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

Findings/Faits saillants :

The licensee has failed to ensure that when a written complaint concerning the care of a resident was received, the home immediately forwarded the complaint to the Director.

A CI was submitted to the MOHLTC related to complaints that had been received by the home from a resident's family. Emails were exchanged between the former DOC and the family members on four dates.

The complaint alleged neglect by staff related to specific issues and care.

The Administrator stated that the initial email to the former DOC did not have the tone of a complaint, however, the a later email dated was a complaint. The Administrator acknowledged that the home had not immediately notified the Director of the written concerns alleging neglect of the resident by their family member.

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that a resident was reassessed and the plan of care reviewed and revised when the resident's care needs changed.

A dated assessment documented that the continence status of the resident had deteriorated during this time period. This was a change from their prior assessment.

A RPN stated that continence assessments were usually in the resident's paper chart. They reviewed the residents paper chart and PCC progress notes and acknowledged that a continence assessment had not been completed. The RPN acknowledged that the resident's continence had changed. The RPN also stated that the resident's care plan had not been updated to reflect the resident's current continence status.

The licensee had failed to ensure that a resident was reassessed and the care plan was not reviewed and revised when the resident's continence care needs changed.

WN #28: 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. (1) Every licensee of a long-term care home shall ensure that the resident's substitute decision-maker, if any, and any other person specified by the resident,
(a) are notified immediately upon the licensee becoming aware of an alleged, suspected or witnessed incident of abuse or neglect of the resident that has resulted in a physical injury or pain to the resident or that causes distress to the resident that could potentially be detrimental to the resident's health or well-being; and
(b) are notified within 12 hours upon the licensee becoming aware of any other alleged, suspected or witnessed incident of abuse or neglect of the resident. O. Reg. 79/10, s. 97 (1).

Findings/Faits saillants :

The licensee has failed to ensure that a resident's SDM was notified within 12 hours upon becoming aware of any alleged, suspected or witnessed incident of abuse or neglect of the resident.

A CI was submitted to the MOHLTC which stated that a resident had reported to the A-DOC that they had been inappropriately touched.

Progress notes stated that the resident reported to the A-DOC that they were inappropriately touched. They continued to voice concerns related to the incident to different staff members for a number of days after their initial report . The A-DOC confirmed that the SDM for the resident was not notified of the alleged incident.

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

The licensee has failed to ensure that a written record of the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents, included the date, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented.

The dated evaluation tool related to prevention of abuse and neglect did not include the names of the persons who participated in the evaluation. The goals and objectives did not have dates identified as to when the changes would be implemented.

The Administrator acknowledged that the annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents did not include the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented. The Administrator confirmed that they completed the annual evaluation independently.

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 107. Reports re critical incidents

Specifically failed to comply with the following:

s. 107. (4) A licensee who is required to inform the Director of an incident under subsection (1), (3) or (3.1) shall, within 10 days of becoming aware of the incident, or sooner if required by the Director, make a report in writing to the Director setting out the following with respect to the incident:
2. A description of the individuals involved in the incident, including,
i. names of any 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.
O. Reg. 79/10, s. 107 (4).

Findings/Faits saillants :

The licensee failed to provide a description of the individuals involved in the incident, including, the names of any staff members or other persons who were present at the incident and the names of staff members who responded to the incident.

A CI was submitted to the MOHLTC related to an unexpected death of a resident. The CI did not document all staff involved and who had responded to the incident.

Interviews completed showed that two PSWs were present as initial responders to the incident with two RNs coming to assist.

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 138. Absences
Specifically failed to comply with the following:

s. 138. (6) A licensee of a long-term care home shall ensure that before a resident of the home leaves for a medical absence or a psychiatric absence, (b) notice of the resident's medical absence or psychiatric absence is given to the resident's substitute decision-maker, if any, and to such other person as the resident or substitute decision-maker designates,
(i) at least 24 hours before the resident leaves the home, or
(ii) if circumstances do not permit 24 hours notice, as soon as possible. O. Reg. 79/10, s. 138 (6).

Findings/Faits saillants :

The licensee has failed to ensure that before a resident left the home for a medical absence or a psychiatric absence, notice of the resident's absences was given to the resident's SDM.

A CI was submitted to the MOHLTC related to resident care concerns and a transfer to hospital.

An email was sent by the family to the previous DOC which alleged the family/SDM had not been notified of the resident's transfer and admission to hospital.

The SDMs stated that they had not been notified until the resident was already admitted to the hospital. The Administrator acknowledged that the home had not notified the SDM as required.

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*

Issued on this 24th day of October, 2019 (A2)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHERRI COOK (633) - (A2)
Inspection No. / No de l'inspection :	2019_610633_0005 (A2)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	026972-18, 029984-18, 029985-18, 030552-18, 030671-18, 032410-18, 032465-18, 033050-18, 033051-18, 033052-18, 033053-18, 033054-18, 033055-18, 033763-18, 000531-19, 000996-19, 001198-19, 001537-19, 003044-19, 004107-19, 005399-19, 005673-19, 005849-19, 005965-19, 006024-19 (A2)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Oct 24, 2019(A2)
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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 8. (3) Every licensee of a long-term care home shall ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times, except as provided for in the regulations. 2007, c. 8, s. 8 (3).

Order / Ordre :

The licensee must be complaint with s. 8.(3) of the LTCHA.

Specifically, the licensee must:

A) Ensure that at least one registered nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and
present in the home at all times, except as provided for in the regulations.

B) Track RN vacancies and recruitment strategies implemented. Documentation must be maintained at the home.

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 ensure that at least one registered nurse was on duty and present in the home at all times.

Two complaints received by the Ministry of Health and Long-Term Care (MOHLTC) were related to a 24/7 registered nurse (RN) not working at the home.

Two Human Resources (HR) reports for a specific time period documented that there was no RN working at the home for five full shifts and two partial shifts.

Three registered staff all said that there was not always a RN working on every shift. The Administrator agreed that 24/7 RN was required and they recalled a few times where there was no registered nurse working.

The licensee failed to ensure that there was a RN working and present at the home for five full shifts and two partial shifts during a specific time period.

The severity of the issue was a level 2, potential for actual harm/risk and the scope of the issue was a level 3, widespread. The home had a level 3 compliance history that included:

-VPC from inspection 2017_610633_0023 issued January 9, 2018;
-written notification (WN) from inspection 2016_260521_0037 issued September 28, 2016.
(633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 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: 2018_580568_0014, 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 ensure:

1) That any person who has reasonable grounds to suspect that the following had occurred or may occur, immediately report the suspicion and the information upon which it was based to the Director:

A) Improper or incompetent treatment or care of a resident that resulted in harm or risk of harm.

B) 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.

2) That all Management of the home review the MOHLTC memo titled "Clarification of Mandatory and Critical Incident Reporting Requirements" dated August 31, 2018. A record of the completed review and Management sign off must be maintained at the home.

Grounds / Motifs :

1. CO #002 from inspection #2018_580568_0014 was reissued on October 26, 2018, with a compliance due date of January 3, 2019. CO #002 stated:

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.
iii) Misuse or misappropriation of a resident's money.

The licensee completed iii) of CO #002.

The licensee has failed to be compliant with s. 24 (1) of the LTCHA. The licensee failed to ensure that when a person had reasonable grounds to suspect that improper care of a resident that resulted in harm or risk or harm to a resident occurred, suspicion and the information it was based upon was reported to the Director immediately.

This inspection was completed as FU to compliance order (CO) #002 from #2018_580568_0014 related to reporting to the Director immediately.

The home's compliance action plan was not implemented and stated that after immediately being informed of any alleged suspected or witnessed incident of abuse or neglect of a resident the Administrator would ensure a critical incident report (CI) was submitted to the Director within the required timelines.

A) Two incidents of alleged abuse/improper care of a resident were not reported immediately to the Director as required.

i) A CI was submitted to the MOHLTC which stated that an identified resident had reported to the Acting DOC (A-DOC) that they had been inappropriately touched.

A progress note stated the date of the incident. The home did not submit the allegation of abuse to the Director until six days later. The after-hour pager was not called. The progress notes also stated that the resident continued to voice concerns related to the allegation to different staff members after the incident occurred. The Administrator and A-DOC both confirmed that the incident of alleged abuse was not reported immediately to the Director as required.

ii) A registered staff member said that an identified resident sustained an injury during a transfer by staff on a specific date. The staff member also said they had told the previous Director of Care (DOC) that a CI report should be submitted to the MOHLTC. The incident should be investigated related to the improper care and transfer of the resident. The staff member and the progress notes both stated that the resident's condition declined after this incident.

The home's CI reports did not include a CI to the MOHLTC related to this incident. The Administrator confirmed that a CI was not submitted to the Director as required.

Two incidents of alleged abuse/improper care were not reported immediately to the Director as required.

The severity of the issue was a level 3, actual harm/risk and the scope of the issue was a level 3, widespread. The home had a level 5 compliance history that included:

-CO from inspection 2018_580568_0014 issued October 26, 2018;
-CO from inspection 2017_610633_0023 issued January 9, 2018. (728)

(532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 25, 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)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 101. (3) It is a condition of every licence that the licensee shall comply with this Act, the Local Health System Integration Act, 2006, the Commitment to the Future of Medicare Act, 2004, the regulations, and every directive issued, order made or agreement entered into under this Act and those Acts. 2007, c. 8, s. 195 (12); 2017, c. 25, Sched. 5, s. 23.

Order / Ordre :

The licensee must be complaint with s. 101. (3) of the LTCHA.

Specifically, the licensee must ensure that:

A) Resident Assessment Protocol's (RAPs) for all residents are generated, reviewed and completed for triggered and non-triggered clinical conditions within seven days maximum of the Assessment Reference Date (ARD).

B) Ensure that an auditing process is developed and fully implemented to ensure that RAI-MDS assessments are completed within the required time frames. This auditing process must be documented including the auditing schedule, the name of the Manager or designate lead conducting the audit, the residents who have been audited, the results of the audit and what date actions were taken with regards to the audit results.

Grounds / Motifs :

1. The licensee has failed to comply with the The Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN). The LSSA stated that the licensee was required to meet the practice requirements of the Resident Assessment Instrument - Minimum Data Set (RAI-MDS) system. Each resident's care and service needs would be reassessed using the MDS 2.0 Quarterly or Full Assessment by the interdisciplinary team and the licensee would also ensure that RAI-MDS tools were used correctly to produce an accurate assessment of the

Health Care Service Provider's (HSP) residents. Resident Assessment Protocol's (RAPs) were to be generated, reviewed and completed for triggered RAPs and non-triggered clinical conditions within seven days maximum of the Assessment Reference Date (ARD) (RAI-MDS Data – 8.1(c)(ii)).

Brucelea Haven has 144 beds however, at the time of the inspection their were 134 residents residing at the home.

An email from the previous DOC to the Resident Assessment Instrument Coordinator (RAI-C) identified concerns related to the outstanding RAI-MDS assessments as this compromised resident care and resident care plans would not be accurate. During a specific period, there were 43 RAI-MDS assessments that were past their ARD and required completion.

The Clinical MDS portal reports documented the current outstanding RAI-MDS assessments by resident home area (RHA). During a specific period, there were 42 RAI-MDS assessments that were past their ARD. The RAI-C confirmed that the RAI-MDS assessments were past their ARD.

A three resident sample in PCC was also completed related to RAI-MDS assessments past their ARD during a specific time period. They ranged from 13 to 40 days past their ARD. The records showed that the resident's RAPs and care plan updates had not been completed.

The RAI-C provided an updated MDS report which documented that 26 RAI-MDS assessments were still past their ARD. When asked what the impact and risk of uncompleted RAI-MDS assessments for the resident was, the RAI-C stated assessments would not be completed and individualized care plans would not be up to date. The risk also included the home missing key care areas.

The licensee did not comply with the conditions to which the licensee was subject. Specifically, the LSSA with the LHIN, under the Local Health Systems Integration Act, 2006, which required the licensee to meet the practice requirements of the RAI-MDS.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 3, widespread. The home had compliance history of 2, multiple unrelated non-

compliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 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 : 004

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 8 (1).

Specifically, the licensee must:

A) Review and revise the home's Skin and Wound Management policy in consultation with a Wound Care Specialist. The date of the review, who attended, changes made and date the changes were implemented must be documented.

B) Ensure that education is developed and implemented related to skin and wound in consultation with the Wound Care Specialist. A record must be maintained of the date of the education, the content and who provided the training. All staff that provide direct care to residents must sign off on the completed education.

C) Review and revise the home's Medication Incident Management policy in consultation with a Pharmacist. The date of the review, who attended, changes made and date the changes were implemented must be documented.

D) Train all registered staff and the DOC or designate responsible for medication incidents, on the Medication Incident Management policies. All staff must sign off on the completed education and documentation must be maintained in the home.

E) Ensure that all staff comply with the home's Head Injury Routine (HIR), Skin and Wound, Management and Medication Incident Management policies.

Grounds / Motifs :

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

Three of the home's policies were not complied with and two of the home's policies were not in compliance with all applicable requirements under the Act.

A) In accordance with O. Reg. 79/10, s. 48(1) and in reference to s. 49(1), the licensee was required to have a falls prevention and management program that provided strategies to monitor residents.

Specifically, staff did not comply with the licensee's falls prevention policy that stated that as part of their falls prevention and management policy staff were required to conduct a Head Injury Routine (HIR) for each unwitnessed fall as a strategy for monitoring residents post fall. Staff were directed to monitor HIR as per the schedule on the form for signs of neurological changes (i.e. facial droop, behavioural changes, weakness on one side, etc).

A dated progress note stated that an identified resident was found lying on the floor. An injury was noted and the resident was unable to state if they had hit their head.

The RAI-C stated that the HIR was to be initiated as the residents fall was unwitnessed however, they were unable to locate the paper HIR form in the resident's chart. The RAI-C stated that the HIR was not initiated for the identified resident's fall on a specific date.

The licensee has failed to ensure the the home's HIR strategy to monitor a resident post fall was followed.

B) In accordance with O. Reg. 79/10, s. 135(2) and in reference to s.115(1) the licensee was required to review, analyze and document all medication incidents to identify changes to improve the medication management system.

Specifically, the home was non-compliant with the home's medication incident management policy. The AS confirmed the home's current policy in use related to medication incidents. The policy stated that the DOC was to review the incident and conduct and document an investigation to determine the root cause, contributing factors and corrective and preventative actions.

i) A medication incident report (MIR) stated that an identified resident received a medication without an order. This medication had been discontinued.

A registered practical nurse (RPN) reviewed the plan of care for the resident and the MIR. Medication orders were usually processed on days and the medication should

have been removed from the medication cart when the medication was discontinued on the day shift.

ii) Another MIR stated that an identified resident received the wrong dose of a specific medication.

Both MIRs did not include any documentation that an investigation and staff interviews had been completed.

The A-DOC reviewed one MIR and said they were involved with this medication incident. The A-DOC acknowledged that they did not interview staff or investigate. The Pharmacist reviewed both medication incidents and agreed that an investigation was not documented online on the MIR system related to one MIR. They said that both incidents lacked detail and documentation. The AS was unable to locate any further documentation that had been completed by the DOC or delegate related to an investigation into either medication incident.

The licensee was non-compliant with the home's medication incident management policy that directed the DOC or designate to investigate, interview staff, and maintain documentation related to the investigation to identify root causes and contributing factors to prevent recurrence and reduce risk.

C) The licensee has failed to ensure that where the Act or this Regulation required the licensee of a long-term care home to have instituted or otherwise put in place any policy, that the policy was in compliance with all applicable requirements under the Act and complied with.

Two of the home's policies were not in compliance with all applicable requirements under the Act.

1) In accordance with O. Reg. 79/10 s. 50 (2)(b)(i)(iv), the licensee was required to ensure that a resident at risk of 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 and altered skin integrity and was reassessed weekly when clinically indicated.

The AS provided the home's skin and wound policy and on a different date a RPN

provided a different skin and wound policy. The RAI-C confirmed the correct policy. The policy directed registered staff to conduct weekly wound and skin care rounds, assess for pressure wounds stage II or greater and wounds with other etiologies.

A dated e-mail was sent to registered staff at the home that directed staff that weekly wound assessments for stage I pressure ulcers was not required. The home's documentation related to their skin and wound program included documentation which described a stage I pressure injury.

Four registered staff members were interviewed and they had different processes to manage stage I pressure ulcers. Their stated process also differed from the direction in the home's skin and wound policy.

2) In accordance with O. Reg. 79/10, s. 116(3) and in reference to s.115, the licensee was required to have a system in place to review the quarterly medication management evaluations and medication incidents from the previous year annually.

Specifically, the home's medication incident management policy did not include a process to review the quarterly medication incidents from the previous year.

The home's medication management evaluation did not specify that the annual evaluation would include a review of the quarterly evaluations in the previous year as referred to in s. 115, using an assessment instrument designed specifically for this purpose.

The AS said that medication incidents were reviewed at the Professional Advisory Committee (PAC) meetings.

The home's annual medication management evaluation and assessment tool and dated PAC meeting minutes did not include a review of the quarterly medication incidents from the previous year. The Pharmacist said they met with the previous DOC informally on several different days to complete the annual medication management evaluation. A detailed review was not completed.

The home's Falls Prevention and Management, Medication Incident Management and Skin and Wound Care Management Program policies were not complied with and the home's Skin and Wound Care Management Program and Medication

Incident Management policies were not in compliance with all applicable requirements under the Act.

The severity of the issue was a level 2, potential for actual harm/risk and the scope of the issue was a level 3, widespread. The home had a level 3 compliance history that included:

-VPC from inspection 2017_610633_0023 issued January 9, 2018. (532)(728) (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 2019

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: 2018_580568_0014, CO #005;

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 ensure:

A) That an identified resident, and any other resident, are free from neglect by the licensee or staff.

B) That an identified resident, and any other resident, are free from abuse by anyone.

Grounds / Motifs :

1. CO #005 from inspection 2018_580568_0014 related to s.19(1) was on reissued October 26, 2018. The compliance due date was January 3, 2019. Order #005 stated:

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

Specifically, the licensee must:

1. Ensure that six identified resident's resident's, and any other resident are free from neglect by the licensee or staff.

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

This inspection was completed as FU to CO #005 from #2018_580568_0014 related to duty to protect.

The licensee has failed to protect an identified resident from neglect. There was a pattern of unsafe transferring techniques at the home and staff not following the resident's assessed safety needs and care plan related to their transfer status.

O. Reg. 79/10, s. 5. defined neglect as the failure to provide a resident with the care, services or assistance required for their health, safety or well-being, and included a pattern of inaction that jeopardized the health, safety or well-being of one or more residents.

A) Three unsafe transfers of an identified resident by staff occurred which resulted in injuries.

i) A RPN said that the resident sustained an injury related to a transfer and the resident's health had declined since then.

A dated report stated that the resident was transferred using the extensive assistance of one person twice on the date that the incident occurred. It was also documented that the resident was transferred multiple times using one person assistance during a specific month. However, the resident's plan of care stated that the resident required a two person physical assist for transfers.

The RAI-C said that the resident required two staff members to physically assist them for their transfers at the time this incident occurred. They also said that the resident was not transferred safely by the identified PSW which resulted in an injury.

ii) Two CI's were submitted to the MOHLTC related to the same resident. The CI's documented a transfer by staff that had resulted in injuries.

One CI documented that the resident was transferred with one person and the resident's plan of care stated that they required a one person transfer. However, the resident's care plan documented that their transfer status was changed to two person physical assist and they required two staff assistance for their transfers at the time of the incident.

The home's investigative notes, POC, and the identified PSW stated that they had transferred the resident alone. The RAI-C said that the plan of care stated that the resident required two staff members for transferring. The resident sustained an injury.

iii) The second CI documented that a PSW found the resident with an injury.

The resident's plan of care related to their transfer status stated they required total care of two staff members as the resident was unable to assist.

At the time of the incident, the identified PSW had expressed that they would prefer to lift the resident themselves. However, they did not remember the resident having an injury or this incident.

A PSW said that care staff were completing transfers and using lifts incorrectly when working short staffed however, this also occurred when the home was not short staffed. They also said that residents that required two staff for their transfer per their plan of care were being transferred with one staff member.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques per the resident's assessed safety needs when assisting an identified resident with their transfers. The pattern of not following the resident's plan of care related to their transfer status resulted in repeated injuries to the resident.

B) The licensee failed to protect an identified resident from abuse.

O. Reg 79/10 s. 2(1) defined physical abuse as the use of physical force by a resident that caused physical injury to another resident.

A CI report was submitted to the MOHLTC which documented an altercation that had occurred between two residents. One resident sustained an injury.

A complaint was received by the MOHLTC related to a concern for the resident's safety.

The care plan for the identified resident included specific responsive behaviours.

A RN stated that as a result of the altercation, one resident was injured and required treatment. The progress notes documented that the resident was emotionally upset after this incident occurred.

Three staff all said that abuse included physical and emotional.

The licensee failed to protect an identified resident from abuse by another resident on a specific date.

C) The licensee failed to protect an identified resident from neglect by staff.

A CI was submitted to the MOHLTC which stated that an identified resident fell and sustained an injury.

A dated risk management report and progress note documented that the resident was found on the floor. The resident had injuries and complained of pain.

The home's investigation notes stated that a RPN left the resident unattended despite being aware that the resident was at risk of falling. The registered staff also did not follow-up with the resident's pain when the resident was calling out in pain.

A staff member reported that they were working when the incident occurred and they had noted the resident at risk of falling and calling out in pain. They said that more could have been done to prevent the fall from occurring and the nursing staff had neglected the necessary care for the resident to prevent their fall.

The identified RPN said that when they repositioned the resident, the resident screamed in pain and leaned forward right after. The RPN also stated that they left the floor and did not communicate with staff that they were leaving the unit. PSWs were in resident rooms checking on other residents. The RPN acknowledged that they left the unit while the resident was crying out in pain. They agreed that the resident was left at risk.

The Administrator said that the home's investigation revealed that staff had left the resident unattended crying out in pain. The resident fell and sustained an injury as a result.

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

The licensee failed to protect an identified resident from neglect by staff on a specific date.

The severity of the issue was a level 3, actual harm/risk and the scope of the issue was a level 2, pattern. The home had a level 5 non-compliance history that included:

-CO from inspection 2018_580568_0014 issued October 26, 2018;
-CO from inspection 2017_610633_0023 issued January 9, 2018. (532)(728)

(737)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 25, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Linked to Existing Order / Lien vers ordre existant: 2018_580568_0014, 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:

A) Ensure that the written staffing plan required for the organized program of nursing services and the organized program of personal support services under clause 8(1)(a)(b) of the Act, provides for a staffing mix that is consistent with residents assessed care and safety needs.

B) Develop, document and implement a process in the home for the leadership to evaluate, at a minimum of bi-weekly, whether the written staffing plan is consistently meeting the residents assessed care and safety

needs in the home.

This evaluation must include:
i) A written analysis of the care and safety needs of each group of residents in each section of the home which includes, but is not limited to, the residents' care needs related to their Activities of Daily Living (ADLs): transfers, twice weekly bathing, toileting routines, repositioning and monitoring, oral care, assistance at all meals, timely medication administration, and weekly assessments for altered skin integrity. The analysis must also include RAI-MDS assessments, Family Care conferences and Circle of Care Assessments.

ii) The written analysis must identify whether the staffing plan for each section of the home, as per the HR staffing reports "County of Bruce HR Indicators-All nursing hours" and the completed "County of Bruce Daily Schedule Listings, is meeting the care and safety needs of all residents living in the home, RAI-MDS assessments by their ARD and Family Care conferences and Circle of Care assessments timelines. All documentation related to the analysis must be maintained at the home.

iii) The analysis must include the variances related to vacant registered and PSW positions and the back-up staffing plan implementation.

D) The evaluation must document the date it was conducted, the names and signatures of the participants, the information analyzed, the results of the evaluation and analysis and the date actions were taken, by whom and the outcome.

E) Ensure that the revised staffing plan, including the revised staffing back-up plan, is implemented and complied with.

Grounds / Motifs :

1. CO #003 from inspection 2018_580568_0014 related to O. Reg. 79/10, s. 31 (3) was reissued on October 26, 2018. The compliance due date was February 22, 2019. CO #003 stated:

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.

The home failed to complete step 1).

The home completed step 2) documented an evaluation of their staffing plan however, there was not enough PSW hours on each home area to ensure there were 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. There was also not enough registered staff hours on each home area to ensure there were enough staff to meet the residents assessed care and safety needs including timely medication administration and completion of assessments for altered skin integrity.

The home completed step 3) Management in the home were aware of daily staffing shortages that impacted resident care, however, there were no detailed plans in place and implemented to ensure that residents received the care and assistance they needed..

This inspection was completed as FU to CO #003 from inspection 2018_580568_0014 related to the home's staffing mix.

1) The home's staffing plan was not implemented, and staffing shortages and lack of leadership supports impacted resident care in multiple care areas.

A) The Administrator provided a copy of the home's annual evaluation of the staffing plan which included the required daily staffing complement for the home.

B) The HR reports during a specific time period showed that multiple nursing staff worked overtime. The HR-S confirmed the overtime hours worked. Despite the overtime by all disciplines, the home was unable to maintain their staffing plan levels for RNs, RPNs and PSWs. Three RPNs and three PSWs said that there was a strain on staff and overtime and doubles were worked constantly.

C) The HR reports also showed that the home did not have the full complement of PSW staff despite the overtime worked by PSWs daily. The HR-S confirmed the PSW hours worked. The Administrator agreed that the home was short PSWs during the identified time period and they acknowledged that staff were working overtime.

D) A HR report identified the home's staffing vacancies. There were no full-time positions being recruited. The job postings online and related documentation provided by HR showed that advertising was not completed as outlined in the home's recruitment plan.

2) The staffing shortages impacted resident care in multiple areas:

A) Transfers;

i) Two residents were transferred by one staff when the plan of care directed that the resident required two-person physical assistance. Three improper transfers resulted in significant injuries to one resident.

ii) A staff member was observed using a mechanical lift independently to transfer a resident. The staff acknowledged completing the transfer without assistance and stated most of the PSWs on the unit did not do two-person transfers. When asked why, they said it was a very heavy floor with a lot of residents who needed a transfer with a mechanical lift. Often, they worked short. A PSW said that this placed the residents at risk for falls and injuries. Two staff both said that it was difficult to get assistance to provide care to residents. Two RPNs said there were times when there was one PSW and themselves running the unit. Transfers were difficult to get done.

Two staff and the A-DOC said that the impact to residents when they worked short was that staff tried to complete all of the transfers at once. One PSW explained that they needed to get residents transferred and into bed right after supper or the RPN and the one PSW would be left to do this in the evening. The A-DOC said one-person transfers occurred because of the lack of staff at the home.

B) Twice weekly bathing according to preference;

A complaint was received by the MOHLTC related to missed bathing at the home.

i) Record review of the plan of care for four current residents and staff interviews were completed related to bathing. Four of four residents did not receive their baths twice weekly. Four staff all said that bath shifts were pulled to the floor and resident baths did not get done. Five staff all said baths may be missed if there was not enough staff to do the baths. When asked if the home's staffing plan allowed for staff to meet the bathing care needs of the residents staff said no. If the home was short, the PSW struggled to get all the residents up or back into bed and there was no time for bathing. The A-DOC acknowledged that bathing was missed and agreed that bathing was not the priority when working short staffed.

ii) The staff schedules showed that the home did not have the PSW shifts filled that were dedicated to bathing during a specific time period.

C) Toileting routines;

Record review of the plan of care for three residents and staff interviews were completed related to toileting. Three of three residents did not receive

toileting/continence care per their assessed needs and plan of care. Multiple PSWs stated that continence care was difficult to get done when the home was short staffed.

D) Repositioning and monitoring;

Record review of the plan of care for three residents and staff interviews were completed related to repositioning. Three of three residents were not repositioned as per their assessed needs and care plan. Multiple PSWs stated that all residents were not repositioned every two hours as there were not enough staff at the home. There were many competing care priorities and some areas of the home had a heavier workload then others.

E) Oral care;

Observations, record review of the plan of care for four residents, and resident and staff interviews were completed related to oral care. Four of four residents did not receive oral care twice daily before breakfast and before their bed time as required. Three PSWs all said that oral care should be completed twice daily before breakfast and bed time and this was not done because of the staffing shortages at the home. Another PSW stated that oral care was provided in the afternoon to help the evening staff out when short staffed. However, two PSWs both said that oral care was signed off as provided when it was not.

F) Assistance at all meals;

Observations indicated that seven residents did not receive the assistance they required for meals. Meals were rushed and there was not enough staff to ensure that one staff assisted only two residents at a time. A PSW said that even when the home was not short staffed, it was difficult to feed all the residents.

A PSW said that when the home was short an RPN and they had to work two units, the RPN was unable to assist in the dining room for meals. When asked what the impact of working short had on feeding, the PSW said that residents did not get a full meal. Another PSW explained that residents who were not cognitively aware were impacted the most. They did not receive the assistance and time they required to eat. The meal was often cold by the time it was served. The PSW explained that

residents fell asleep waiting and therefore did not eat or drink as well. A RPN said that they relied on family for feeding residents at meals.

G) Timely medication administration;

Observations, record review of the plan of care for three residents, the home's related documentation, and staff interviews were completed related to timely medication administration. Three of three residents received their time sensitive medications late and not as prescribed. Four RPNs and the RAI-C all said that when working short they had 48 residents to give medications to, residents had to wait, and medications were late. They also said that the risk of medication errors increased when working short staffed.

H) Completion of MDS assessments;

Staff interviews, RAI-MDS assessments for three identified residents and the home's related MDS reports showed that the RAI-MDS assessments were not completed per the Long-Term Care Home Service Accountability Agreement (LSSA) with the Local Health Integration Network (LHIN). The completion of RAI-MDS assessments was impacted by insufficient front line and leadership staffing. RAPS and resident care plans were not up to date.

I) Assessments for altered skin integrity;

Record review of the plan of care for three residents and staff interviews were completed related to the completion of weekly skin assessments. Three of three residents did not receive weekly skin assessments as required. A RPN said that staffing played a role in wound assessments and whether they were done. They explained that with the resident workload there was no time for paperwork. Another RPN said that wound treatments, wound care and dressings were missed when working short.

J) The RAI-C and the home's related documentation showed that documentation was not completed for two types of meetings which discussed the residents' plans of care. The RAI-C said that this was due to staff not having enough time, and the staffing shortages at the home.

K) Two residents were denied admission to the home and one resident was denied returning to the home. The reason provided was related to the lack of staff at the home that was required to provide the care the residents needed. The family of one resident, a BSO-RPN, the A-DOC and the Administrator all confirmed that this occurred due to the insufficient staffing at the home.

3) The licensee has failed to ensure that the home's staffing plan mix promoted continuity of care by minimizing the number of different staff members who provided nursing and personal support services to an identified resident.

A) On a specific date an identified resident had specific symptoms.

Two registered staff stated that they noted that the resident had specific symptoms. One RN indicated that they were not familiar with the resident. They did not consider any other etiologies/causes for the resident's symptoms. They were advised to get specific orders. The RN explained that they were unsure how to proceed as they had not been trained by the home related to a specific treatment and orders. Another RN had not been provided orientation and had worked the floor by themselves. Two RNs indicated that they were not familiar with the resident. The RN said they had not worked this floor and their actions were based on the previous night nurses report. A medication error occurred. The RN also said that the home was short registered staff.

The substitute decision maker (SDM) indicated that they were not provided the opportunity to have input into the treatment plan.

The RAI-C explained that the two RNs involved with this incident were new to the home and they had not received their orientation. The A-DOC acknowledged that the home was short staffed when the incident occurred.

B) There were unclear and incomplete standing orders related to a specific treatment.

C) The centralized scheduling system and staff shortages did not promote the continuity of care by minimizing the number of different staff members who provided nursing and personal support services to each resident. Call outs for shifts were by designation and did not include the RHA.

A PSW said when they worked, and there were call ins to another unit, they pulled them to work that unit. Two RPNs said they were placed wherever there was a hole, and this may not be their home unit. Two staff said that staffing at the home was not better and there was not enough staff. Two staff both said they were called constantly to pick up shifts and staff were switched around on the units last minute. Four staff all said that the home's staffing system lacked continuity in providing resident care as staff were not familiar with the residents. The scheduling supervisor (SS) said that covering shifts was constant and there was not enough staff to cover the required shifts at the home.

4) The PCC dashboard documented staff shortages during a specific time period.

5) Leadership supports;

A) Observations and staff interviews showed that management and HR all worked daytime hours Monday to Friday. The registered staff were responsible for covering the multiple daily staff shortages after-hours on evenings and weekends which impacted the time available for resident care. At times, the registered staff were also managing staffing shortages on days.

B) Observations, staff interviews, and HR reports showed that the home lacked senior nursing supports. The Administrator said that the primary concern was that there were no senior staff at the home.

C) HR reports and staff interviews showed that the A-DOC was not always present at the home in their capacity as A-DOC. They also worked floor shifts to ensure that there was 24/7 RN coverage. There was not always a RN working at the home.

Several staff explained that because of the home's compliance problems, there were more and more duties put on the charge nurses which was difficult with the chronic staff shortages at the home. They also said the way management dealt with their compliance problems was not effective.

6) The home's compliance action plan and annual evaluation of the staffing plan were not implemented.

The plan of care for identified residents, the home's related documentation, multiple staff of all disciplines at the home, the SS, the A-DOC and the Administrator all said that the home's current staffing mix and staffing shortages did not promote continuity of care and did not ensure that there were enough direct care staff/hours to meet the residents' assessed care and safety needs. This included leadership supports, transfers, twice weekly bathing, toileting routines, repositioning and monitoring, oral care, assistance at all meals, timely medication administration, completion of MDS assessments and weekly assessments for altered skin integrity, documentation, admissions/discharge, orientation and palliative care. Further evidence is contained in the compliance orders report.

The severity of the issue was a level 3, actual harm/risk and the scope of the issue was a level 3, widespread. The home had a level 5 compliance history that included:

-CO/Director Referral (DR) from inspection 2018_580568_0014 issued October 26, 2018;
-CO from inspection 2017_610633_0023 issued January 9, 2018. (633)(728)(532) (659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 16, 2019(A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 007

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

Linked to Existing Order / Lien vers ordre existant: 2018_580568_0014, CO #001;

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 must ensure that:

A) Leadership immediately investigates every alleged, suspected or witnessed incident of abuse and neglect of a resident.

B) That all components of the investigation per the home's Abuse policy, are documented and the investigation record is maintained at the home.

C) That the Brucelea Haven Long Term Care compliance action plan is implemented including, the Administrator reviewing the investigation file for completeness. The date of the review must be documented.

Grounds / Motifs :

1. CO #001 from inspection #2018_580568_0014 was reissued on October 26, 2018, with a compliance due date of January 3, 2019. CO #001 stated:

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 know 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 home maintains the investigation record.

The licensee failed to be compliant with s. 23. (1) of the LTCHA. The licensee has failed to ensure that every incident of alleged abuse and improper care that the licensee knows of, or that is reported to the licensee, was immediately investigated.

This inspection was completed as FU to CO #001 from inspection #2018_580568_0014 related to alleged abuse investigations.

The home's compliance action plan was not implemented and stated that one lead support investigator would complete the investigation immediately and at the end of the investigation the Administrator would review the file for completeness.

A) Three allegations of abuse/improper care that the licensee knew of were not immediately investigated as required.

i) A CI was submitted to the MOHLTC that stated that an identified resident reported to the A-DOC that they had been inappropriately touched.

A dated progress note stated that the resident reported to the A-DOC that they were

inappropriately touched. The resident voiced concerns related to the incident to different staff members for number of days after their initial report.

The home's investigation notes indicated that the Administrator did not initiate the investigation until 20 days after the resident reported the initial allegation to staff. The A-DOC said that the investigation notes from the resident were not received right away as they were not aware of the procedure. The A-DOC and Administrator confirmed that the investigation was not immediately started.

ii) A registered staff member said that they had told the previous DOC that an incident required an investigation as they had concerns related to the improper transfer of the resident by staff.

The Administrator said that because a CI was not submitted related to this incident, an investigation was unlikely to have occurred.

iii) A CI was submitted to the MOHLTC related to an incident that resulted in an injury to an identified resident and a significant change in their status.

A staff member said that they spoke to the Administrator about the incident and their suspicion of improper care/transfer. They said that they had concerns regarding how the resident was transferred that day.

The home's investigative notes did not include an investigation or any other related documentation. The CI did not document that an investigation occurred related to this incident. The Administrator said that the investigative notes related to this incident consisted of the CI report.

The licensee failed to ensure that an investigation was completed immediately related to the allegation of abuse of a resident and when there was a suspicion of improper transfers resulting in injury to another resident.

The severity of the issue was a level 2, potential for actual harm/risk and the scope of the issue was a level 3, widespread. The home had a level 5 compliance history that included:

-CO from inspection 2018_580568_0014 issued October 26, 2018;

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

-CO from inspection 2017_610633_0023 issued January 9, 2018.

(532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Jun 25, 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 : 008

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

Linked to Existing Order / Lien vers ordre existant: 2018_580568_0014, CO #007;

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 s. 23 (2) of the LTCHA.

Specifically, the licensee shall ensure that:

A) 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.

B) 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. 107(4).

Grounds / Motifs :

1. CO #007 from inspection #2018_580568_0014 was reissued on October 26, 2018, with a compliance due date of January 3, 2019. CO #007 stated:

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).

The licensee failed to be compliant with LTCHA, 2007 S.O. 2007, c. 8, s. 23 (2). The licensee has failed to ensure that the results of the abuse investigation were reported to the Director.

This inspection was completed as FU to CO #007 from inspection #2018_580568_0014 related to reporting alleged abuse investigations to the Director.

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

A CI was submitted to the MOHLTC that stated that a resident had reported that they overheard a PSW yell at another identified resident. The resident had asked the staff to provide them with a specific care. The resident reported that the PSW yelled a comment related to not providing the care.

The home's investigation notes identified that the investigation was initiated however, there were no notes relating to the outcome of the investigation and the CI to the Director was not amended. The A-DOC and Administrator reviewed the CI and said that the CI was not amended and the results of the alleged verbal abuse were not reported to the Director as required.

The severity of the issue was a level 2, potential for actual harm/risk and the scope of the issue was a level 1, isolated. The home had a level 5 compliance history that included:

-CO from inspection 2018_580568_0014 issued October 26, 2018;
-CO from inspection 2017_610633_0023 issued January 9, 2018. (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 25, 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 : 009

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 44. (7) The appropriate placement co-ordinator shall give the licensee of each selected home copies of the assessments and information that were required to have been taken into account, under subsection 43 (6), and the licensee shall review the assessments and information and shall approve the applicant's admission to the home unless,
(a) the home lacks the physical facilities necessary to meet the applicant's care requirements;
(b) the staff of the home lack the nursing expertise necessary to meet the applicant's care requirements; or
(c) circumstances exist which are provided for in the regulations as being a ground for withholding approval. 2007, c. 8, s. 44. (7).

Order / Ordre :

The licensee must be compliant with s. 44. (7)(9) of the LTCHA.

Specifically, the licensee must ensure that:

A) Before refusing an applicant's admission to the home, circumstances must exist which are provided for in the regulations to support withholding approval.

B) Written notices withholding approval for admission must include a detailed explanation of the supporting facts, as they related to both the home and the applicant's condition and requirements for care, and an explanation of how the supporting facts justify the home's decision to withhold their approval.

Grounds / Motifs :

1. The licensee has failed to ensure that the home approved two applicant's application for admission to the home.

A complaint was received by the MOHLTC related to the admission refusal of an applicant by the home. The complainant stated that the refusal was related to the insufficient staffing at the home to provide the required care.

A) The dated refusal letter sent to the applicant and their SDM by the home stated that the reasons for refusal were staffing issues and responsive behaviours.

The South West Local Health Integration Network (SW-LHIN) Patient Care Manager (PCM) reviewed their records and said that at the time of application for admission to the home the applicant's behaviours were managed. The previous DOC had said at the time that there were significant staffing issues to support the applicant in their transition to the home. Supports to assist the applicant's transition were offered but despite the offer, the home refused the applicant's admission. The resident was ultimately placed at another home.

Four staff said they were aware of resident behaviors and they had received training related to responsive behaviours. The home had a secure unit, an internal BSO program and access to internal and external resources related to behaviours. The BSO-RPN stated that BSO shifts had been reduced due to the staff shortages. They said they were called to the floor or BSO just did not get scheduled when the home was working short staffed.

The Administrator said they declined admission to the applicant and this was related to the lack of a social worker at the home and the inability of the home to provide one to one staffing. The Administrator said that their special care unit's primary criterion was residents who were at risk of exit seeking.

B) The dated refusal letter sent to another applicant and their SDM by the home stated staffing issues and a clinically complex case.

A dated written review of the applicant's application was completed by the A-DOC. There were no significant health or behavior issues documented however, the reason for the decline was stated as a clinically complex treatment.

The SW-LHIN PCM reviewed their records and said that at the time of application to the home the applicant no longer required the treatment. The LHIN had questioned

the home related to their decline for admission and their reasons. The home later offered the applicant admission however, they refused and were ultimately accepted at another home.

The BSO-RPN said they had a recent resident at the home with this treatment. The treatment was in the scope of practice for registered staff members. The LHIN would provide supports to the home. The A-DOC agreed that treatment was in the scope of nursing practice and the applicant's admission decline was not related to the staff's lack of knowledge. The A-DOC said that the applicant was declined due to staff shortages at the home and the risk for staff to monitor the treatment when the home was working short. The A-DOC was not aware that the treatment had been discontinued.

The licensee did not lack the physical facilities necessary to meet one applicant's care requirements and staff of the home did not lack the nursing expertise necessary to meet two applicants' care needs. There were no circumstances which were provided for in the regulations for withholding approval for their admissions to the home.

2. A complaint was received by the MOHLTC related to the admission refusal of an applicant. The complainant stated that the reason for refusal was identified as insufficient staffing at the home.

Two written letters withholding approval for admission did not include a detailed explanation of the supporting facts, as they related to both the home and the applicant's condition and requirements for care. An explanation of how the supporting facts justified the home's decision to withhold approval was not included.

The AS and A-DOC reviewed the two refusal letters and agreed that they did not contain a detail explanation with supporting facts as to why the applicants were declined.

The two refusal letters did not meet the requirements of s. 44(9)(b) and s. 44(9)(c), of the LTCHA.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 3, widespread. The home had compliance history of 2, multiple unrelated non-

compliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 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 : 010

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must ensure:

A) That four identified residents, and all residents, are provided bathing by the method of their choice at a minimum twice per week.

B) That there is a written process in place that tracks the residents' bathing preferences, by which method they were bathed, when they were bathed and when bathing was missed.

C) That an auditing process is developed and fully implemented to ensure that residents are being bathed by the method of their choice. This auditing process must be documented including the auditing schedule, the name of the Manager or designate lead conducting the audit, the residents who have been audited, the results of the audit and what date actions were taken with regards to the audit results.

D) The audit includes variances by resident home areas (RHA).

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 ensure that four residents were bathed, at a minimum of twice a week by the method their choice.

Dated assessments and care plans for four identified residents stated their preferences related to bathing.

The plan of care for the identified residents showed that they were dependent on staff for bathing and care. All four residents did not receive bathing twice weekly during a specific time period. Four staff agreed that the residents had not had two baths per week as required. The A-DOC agreed that residents should be bathed at least twice a week.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 3, widespread. The home had compliance history of 3, related noncompliance
that included:

-VPC from inspection 2018_580568_0014 issued October 26, 2018;
-VPC from inspection 2017_610633_0023 issued January 9, 2018;
-VPC from inspection 2016_260521_0037 issued September 28, 2016. (633)
(659)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 02, 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 : 011

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 34 (1).

Specifically, the licensee must ensure:

A) That four identified residents, and all residents, are provided oral care in the morning and evening, including the cleaning of dentures.

B) That there is a written process in place that tracks the residents' oral care and documentation.

C) That an auditing process is developed and fully implemented to ensure that residents are receiving oral care twice daily in the morning and evening and the care is documented. This auditing process must be documented including the auditing schedule, the name of the Manager or designate lead conducting the audit, the residents who have been audited, the results of the audit and what date actions were taken with regards to the audit results.

Grounds / Motifs :

1. The licensee has failed to ensure four residents received oral care to maintain the

integrity of their oral tissue, including mouth care in the morning and evening.

A) A PSW and the plan of care for an identified resident stated that the resident had most of their natural teeth. The resident was totally dependent on staff assistance for their oral care.

The resident stated they did not receive staff assistance to clean their teeth and for mouth care twice daily.

A dated progress note stated that the resident had a symptom while brushing their teeth. A dated report showed multiple times that oral care was provided after their breakfast meal and in the afternoon before the dinner meal and not in the evening before bedtime as required.

B) The plan of care for another resident stated that they had full upper and lower dentures. The resident was totally dependent on staff assistance for their oral care.

A dated report showed multiple times that oral care was documented as provided to the resident in the afternoon. Three staff all said that dentures should be cleaned before breakfast and in place for all meals and cleaned at night before bed.

C) The plan of care for another resident stated they were totally dependent on staff for their oral care. Staff were directed on how to provide their oral care.

Two observations showed the resident's oral membranes appeared dry.

Dated reports related to oral care documented three instances when oral care had not been provided twice a day. A PSW acknowledged that oral care had not been provided to the resident. They also said they had documented the oral care as provided for the resident when it was not.

D) The progress notes for another resident documented a family concern related to the resident's dental status.

The plan of care for the resident stated they were totally dependent on staff for their oral care. Staff were directed on how to provide their oral care.

Three observations showed that the oral care had not been provided.

A dated report related to oral care for the resident documented one instance when oral care had not been provided twice a day. On three specific dates PSWs agreed that oral care had not been provided as required. The documentation showed that oral care was provided to the resident when it was not.

Four staff all said that oral care should be provided with morning care and before bedtime. One PSW stated that staff may complete documentation of the care prior to completing the care and that on occasion oral care may be documented as provided when it was not.

The licensee has failed to ensure that four residents received oral care to maintain the integrity of their oral tissue, including mouth care in the morning and evening.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 3, widespread. The home had compliance history of 2, multiple unrelated non-compliance. (659) (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Aug 02, 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 : 012

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 36. Every licensee of a long-term care home shall ensure that staff use safe transferring and positioning devices or techniques when assisting residents. O. Reg. 79/10, s. 36.

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 36.

Specifically, the licensee must ensure:

A) That all staff use safe transferring and positioning devices or techniques when assisting an identified resident, and all residents.

B) That all PSW staff receive education on transfers and lifts. A written record must be kept of the education that includes who completed the training, the content, and date staff sign off.

Grounds / Motifs :

1. The licensee has failed to ensure that staff used safe transferring techniques when assisting two residents.

A) A dated assessment stated that an identified resident required two person total assistance for transfers and that their mode of transfer was a mechanical lift. The plan of care stated a mechanical lift was required for transfers for safety.

On a specific date, a PSW was observed to use a lift independently to transfer the resident.

The PSW said that the expectation was that there were two persons to assist when a resident was transferred using a lift.

B) Three transfers of an identified resident were completed by staff that were unsafe and not per the residents assessed care and safety needs.

The plan of care documented that the resident required two person physical assist for transfers and they remained a two person physical assist for their transfers at the time of the incidents.

i) On a specific date the resident was transferred using the extensive assistance of one staff member twice. Two staff said that the resident sustained an injury and their health had declined since then. The RAI-C confirmed that the resident required two persons for their transfers.

ii) Two CIs were submitted to the MOHLTC related to the same resident that documented two additional transfers which had resulted in injuries.

The home's investigative notes documented that the PSW had transferred the resident themselves.

One CI submitted to the MOHLTC documented that a PSW found the resident with an injury. The PSW had stated at the time that they would prefer to lift the resident themselves. The identified PSW said that they did not remember the incident.

A PSW said that care staff were completing transfers and using lifts incorrectly. They also said that residents who required two staff for their transfer were being transferred with one staff member.

The home's dated transfer policy stated that PSWs would lift and transfer residents according to their plan of care. Mechanical lifts must have two caregivers present during the lifting/transferring or repositioning procedure.

The licensee has failed to ensure that staff used safe transferring and positioning devices or techniques when assisting two residents which resulted in injuries to one resident.

The severity of the issue was a level 3, actual harm and the scope of the issue was a level 3, widespread. The home had compliance history of 3, one or more related non-compliance that included:

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

-VPC from inspection 2017_610633_0023 issued January 9, 2018. (728) (659)

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

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 : 013

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

Linked to Existing Order / Lien vers ordre existant: 2018_580568_0014, CO #004;

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)(iv).

Specifically, the licensee must:

A) Designate a Wound Care Lead at the home.

B) Ensure that three identified residents, 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) Is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

3) Is repositioned every two hours or more frequently as required including while asleep if clinically indicated.

4) 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.

C) Ensure that an auditing process is developed and fully implemented related to RD referrals, repositioning and weekly skin and wound assessments. This auditing process must be documented including the auditing schedule, the name of the Manager or designate lead conducting the audit, the residents who have been audited, the results of the audit and what date actions were taken with regards to the audit results.

Grounds / Motifs :

1. Order #004 from inspection 2018_580568_0014 related to O. Reg. 79/10, s. 50. (2) was issued on October 26, 2018, with a compliance due date of January 3, 2019. Order #004 stated:

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:

Two identified resident's 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, when clinically indicated.

This inspection was completed as FU to CO #004 from inspection #2018_580568_0014 related to skin and wound care.

Two residents identified in CO #004 were no longer at the home and two residents were substituted for them.

A) The plan of care for an identified resident stated that they were totally dependent on staff for all care. The resident had areas of altered skin integrity which required weekly assessments. The skin and wound assessments showed that a weekly assessment was completed on a specific date, and not again until 10 days later.

i) PSW staff were directed to turn and reposition the resident related to their altered skin integrity at specific times. The report dated during a specific period of time documented that the resident was not repositioned as directed.

ii) The resident's plan of care and the home's dated audit report showed that a registered dietitian (RD) referral was not made with the resident`s new and worsening altered skin integrity. The RD referral was not made until a number of days later, and the RD did not assess the resident until a number of days after.

A PSW said that the resident had areas of altered skin integrity and they required repositioning. Two registered staff said that weekly assessments should have been completed. The RAI-C and the home's related reports stated that the residents wounds had worsened.

B) The plan of care for another resident identified they were at risk for altered skin integrity and they had multiple areas of altered skin integrity.

i) The skin and wound assessments showed that a weekly assessment was completed for three areas on specific dates, and not again until 14 days later. A weekly assessment for another area was completed on a specific date, and not again until 10 days later. A dated progress note did not indicate that one area was healed. As of a specific date, there were no further weekly assessments related to this area of altered skin integrity in the resident's plan of care.

ii) The plan of care for the resident identified that they were totally dependent on two staff for repositioning and they required a specific intervention related to their altered skin integrity.

A PSW agreed that the resident required repositioning every two hours related to their skin sensitivity and altered skin integrity. A dated report showed that the resident was not repositioned as required. The resident`s skin and wound assessments stated that their areas of altered skin integrity had worsened during this time period.

Two registered staff both said that weekly skin assessments should be completed for a resident with altered skin integrity. The RAI-C agreed that the resident should have been assessed weekly and was not.

C) The plan of care for an identified resident stated that they had areas of altered skin integrity.

The skin and wound assessments showed that a weekly assessment was completed on a specific date, and not again until 9 days later. There were no weekly assessments completed on two dates. Three registered staff all said that weekly skin assessments should have been completed.

D) A dated assessments stated a resident was totally dependent on two staff for their repositioning.

The plan of care for the resident documented that staff should turn and reposition the resident every two hours and this included during the night to ensure pressure was relieved. A dated report showed blanks in the documentation.

A PSW stated it should be automatic repositioning every two hours for residents who depended on staff for their mobility and this should be documented. A RPN said that staff should follow the direction in the care plan. The RPN reviewed the documentation for the resident and stated that there were blanks in the documentation which indicated that their repositioning had not been completed.

The licensee has failed to ensure that three residents, who exhibited altered skin integrity, were reassessed at least weekly by a member of the registered nursing staff using a clinically appropriate assessment tool specifically designed for skin and wound. Three residents were not repositioned per their plan of care and one resident did not receive an assessment by the RD. Two of three resident wounds worsened.

The severity of the issue was a level 3, actual harm and the scope of the issue was a level 3, widespread. The home had compliance history of 3, related non-compliance that included:

-CO from inspection 2018_580568_0014 issued October 26, 2018. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 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 : 014

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 73 (2).

Specifically, the licensee must ensure that:

A) No person simultaneously assists more than two residents who need total assistance with eating or drinking.

B) Seven identified residents, and any resident who requires assistance with eating or drinking, are not served a meal until staff are available to assist.

C) That all PSW staff review the home's Pleasurable Dining Experience protocol. A written record is kept of the review that includes the date of staff sign off.

Grounds / Motifs :

1. The licensee has failed to ensure that staff did not simultaneously assist more than two residents who needed total assistance with their eating or drinking. Seven residents did not receive their required assistance for meals.

O. Reg. 79/10, s. 73 (7)(8) states that there should be sufficient time for every resident to eat at their own pace and meals were to be served course by course, unless otherwise indicated by the resident or by the resident's assessed needs.

On a specific date, four residents were observed with meals in front of them and there was no staff present to assist them. Staff were assisting more than two residents at a time. None of the residents ate well, fluids remained untouched and they were not offered dessert. Staff and the meal service appeared rushed.

On a specific date, three residents were observed with with their meal in front of them and no staff were present and seated at the table to assist them. Staff were assisting more than two residents at a time.The main meal was served before the residents had finished their first course. Staff and the meal service appeared rushed.

The plan of care for the seven residents stated that they required total staff assistance for their meals.

The home's pleasurable dining rooms procedure was not implemented.

A PSW confirmed that the expectation was that a resident was not served a meal until there was a staff member to assist. Staff should assist no more than two residents at a time.

The licensee has failed to ensure that seven residents received the required assistance for their meals and that staff did not assist more than two residents at a time.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 2, pattern. The home had compliance history of 2, multiple non-related non-compliance. (659)
(633)

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 : Aug 02, 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 : 015

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,

(a) ensure that alternatives to discharge have been considered and, where appropriate, tried;

(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident;

(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and

(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 148 (2).

Specifically, the licensee must ensure:

A) That before discharging a resident under subsection 145 (1), alternatives to discharge have been considered and, where appropriate, tried in collaboration with the appropriate placement co-ordinator and other health service organizations, making alternative arrangements for the accommodation, care and secure environment required by the resident.

B) Provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident.

Grounds / Motifs :

1. The licensee has failed to ensure that before discharging a resident alternatives to their discharge had been considered and tried in collaboration with the appropriate placement co-ordinator and other health service organizations. A written notice to the resident and/or the resident`s SDM that outlined the supporting facts as they related to the residents condition and justified the licensee's decision was not provided.

An incident occurred and an identified resident was transferred from the home. Interventions had been identified by an external resource and a specific recommendation was not made. A dated assessment stated that the resident`s return to the home was anticipated.

The SDMs were told the resident could not return to Brucelea Haven related to staffing shortages. The family was told they needed to provide more care if the resident was to return. A SDM said that they had no support from specific external resources and the home. There was no other solution but to find somewhere else for the resident to go. The SDMs said that they did not receive any written documentation from the home related to the residents condition with supporting facts that justified the home's decision to disallow the resident to return.

A RPN described interventions in place and in progress for the resident. Resources

were available and staff had been trained. They acknowledged the family involvement with the resident`s care. They said that the home was short staffed, specific BSO shifts were either not scheduled or they were pulled to the floor to cover shifts. The RPN and the Administrator both stated that a specific intervention was not considered for the resident.

The SW-LHIN PCM said that there was no documentation related to the resident and they were unaware of this incident. They said that a case manager was available to provide assistance however, they were not contacted by the home.

The Administrator and physician both agreed that they told the family that they needed to provide a specific care in order to return to Brucelea Haven. The Administrator denied that they discharged the resident but acknowledged that they told the family the resident could not return to Brucelea Haven. The Administrator stated that they were not aware if the LHIN had been contacted or involved and agreed that no written notice to the family was provided to them by the home.

The licensee has failed to ensure that before discharging an identified resident, alternatives to their discharge had been considered and tried in collaboration with a specific external resource and the LHIN. A written notice to the resident's SDM that outlined the supporting facts was not completed.

The severity of the issue was a level 3, actual harm and the scope of the issue was a level 1, isolated. The home had a compliance history of 2, multiple non-related non-compliance.
(633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 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 : 016

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 131 (2).

Specifically, the licensee must:

A) Ensure that drugs are administered to three identified residents, and all residents, in accordance with the directions for use specified by the prescriber.

B) Ensure that an auditing process is developed and fully implemented to ensure that residents are receiving their medications in accordance with the directions for use specified by the prescriber.This auditing process must be documented including the auditing schedule, the name of the Manager or designate lead conducting the audit, the residents who have been audited, the results of the audit and what date actions were taken with regards to the audit results.

C) The audit must identify when the home was working short of RPNs and registered staff.

Grounds / Motifs :

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

A) A dated medication incident report (MIR) and electronic medication administration record (eMAR) stated that a resident received a medication without an order. The

medication had been discontinued. The identified RN gave the medication and did not sign for it. The A-DOC agreed this incident was a medication error and the resident did not receive their medication as prescribed.

B) A dated MIR stated that a resident received the wrong dose of a medication. The RPN had signed that they had given the medication as prescribed however, they had not. The A-DOC reviewed the MIR for the resident and agreed that the resident received the wrong dose.

A drug was administered to two residents that was not in accordance with the directions for use by the prescriber.

C) On a specific date, a RPN was observed working two resident home areas (RHAs) for a total of 48 residents. They said the home was short a RPN and they were administering medications on both units.

i) The physician orders and eMAR for three identified residents stated they had a specific diagnoses. The residents required a specific medication that was prescribed multiple times a day. The dated medication audit reports showed their medication was given outside of an hour of the prescribed time.

The medication audit report also documented nine additional residents that received their medications over an hour after the prescribed time on this shift on both RHAs. The RPN reviewed the documentation and agreed that these medications were given late when working short.

ii) On a specific date, A RPN was observed administering medication to two RHAs. They said they were working short a RPN.

The dated medication audit report documented that seven residents received an identified time sensitive medication late, not as prescribed and outside of the one-hour time frame.

Two registered staff both said that medications were documented on the eMAR when they were given to the resident.

The RPNs said that although they had an hour before or after the prescribed time to

give a medication this was difficult with so many residents. Medication took longer, and residents had to wait. There was also a risk for medication errors and medication incidents when working short. Two RPNs acknowledged the time sensitive medications that were required to control related symptoms. The RPNs and Physician explained that the impact of late medication administration for these specific medications for the resident was potentially increased symptoms. The Physician said that these medications were time sensitive and should be given as soon as possible and/or within the hour of the prescribed time.

The licensee has failed to ensure that drugs, including time sensitive medications to treat specific symptoms, were administered to residents in accordance with the directions for use specified by the prescriber.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 3, widespread. The home had compliance history of 2, multiple unrelated non-compliance. (633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 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 : 017

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

Linked to Existing Order / Lien vers ordre existant: 2018_580568_0014, CO #006;

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) Review all resident transfer logos to ensure they provide clear directions to staff. Maintain documentation of the review that includes who completed the review, the date of the review and the changes made and the date changes were implemented.

B) Ensure that an identified resident, and all residents, are reassessed and the plan of care is reviewed and revised when their continence needs changes.

C) Ensure that the plan of care for an identified resident, and all residents, is followed related to skin and wound care. Specific to an identified resident, that a specific intervention is in place per their plan of care.

D) Ensure that the plan of care for four identified residents is followed, and the care is documented related to continence care.

E) Ensure that an auditing process is developed and fully implemented to ensure that the plan of care for residents is being provided to the residents as specified in their plans of care, and the care provided is documented. This auditing process must include the auditing schedule, the name of the Manager or designate conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results. The written audit must be kept available in the home.

Grounds / Motifs :

1. CO #006 from inspection #2018_580568_0014 was issued on December 24, 2018. The compliance due date was February 22, 2019. Order #006 stated:

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

Specifically, the licensee must:

a) Ensure that the written plan of care for an identified resident and any other

resident in relation to toileting; and a identified resident, 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 an identified resident, 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 an identified resident, and any resident in relation to falls is provided to the resident as specified in the plan.

d) Ensure that an identified resident, 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.

The licensee failed to be compliant with s. 6. of the LTCHA.

This inspection was completed as FU to CO #006 from inspection #2018_580568_0014 related to plan of care.

Four residents identified in CO #006 were no longer at the home. One resident identified in CO #006 was currently at the home and has been identified in this finding.

The licensee has failed to be compliant with LTCHA, 2007, s. 6 (1)(c), s. 6. (10)(b) and s. 6.(7).

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

A CI was submitted to the MOHLTC which documented a transfer that had resulted in an injury.

The resident care plan documented that their transfer status was two-person transfer however, the CI documented that the resident was a one-person transfer.

The home's investigative notes documented a PSW had transferred the resident alone and that the resident was a one-person transfer. The investigative notes included a printed care plan that was in effect at the time the transfer was completed. The care plan documented the resident`s transfer status as two staff physical assist for all transfers.

The identified PSW said that they knew a resident`s transfer status because of the logo above the resident's bed. They said that at the time they completed the transfer the logo above the bed indicated that the resident was a one-person transfer and not two staff.

B) The licensee has failed to ensure that a resident`s plan of care was reviewed and revised when the resident's care needs changed.

A dated assessment for an identified resident documented their status related to continence. The care plan had not been updated. A PSW said that they referred to the care plan for continence care and the level of staff assistance a resident required. A RPN reviewed the resident`s plan of care and stated that the care plan had not been updated to reflect the resident`s current continence status.

C) The licensee has failed to ensure that the skin and wound care set out in the plan of care was provided to a resident as specified in their plan of care.

i) The plan of care for a resident identified that they had areas of altered skin integrity which required a specific intervention.

The resident was observed without the intervention on two dates. A PSW said that the resident required the intervention at all times.

A dated progress note stated the resident sustained an injury and the intervention was not in place. A RPN said the intervention should have been in place and was not. They agreed that the resident sustained an injury as a result.

ii) The licensee has failed to ensure that care set out in the plans of care for four residents related to their continence care was provided to the residents as specified in their plans of care.

The assessments and care plans stated that the four residents required specific care and staff assistance. Documentation showed that the residents did not receive the care they required. Four staff confirmed that the care was not provided.

The severity of the issue was a level 3, actual harm/risk and the scope of the issue was a level 3, widespread. The home had a level 5 non-compliance history that included:

-CO from inspection 2018_580568_0014 issued October 26, 2018;
-VPC from inspection 2017_610633_0023 issued January 9, 2018;
-VPC from inspection 2016_260521_0039 issued September 28, 2016;
-VPC from inspection 2016_303563_0020 issued July 16, 2016. (728)(659)

(633)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jul 19, 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 : 018

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:

1. The Residents' Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protections afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities.
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

Order / Ordre :

The licensee must be compliant with LTCHA 2007, c. 8, s. 76. (2) (7).

Specifically, the licensee must ensure:

A) That all registered staff receive orientation per the home's orientation process.

B) That all registered staff receive education related to palliative care and the home's related processes including palliative care orders. Annual education is provided thereafter.

C) That all registered staff and the wound care lead receive education related to skin and wound including assessment.

D) That the skin and wound education is developed according to best practices and in consultation with a Wound Care Specialist.

E) That all direct care staff receive education related to falls prevention and management including assessment.

D) That a written record is kept of the education that includes who completed the training, the content, and date staff sign off.

Grounds / Motifs :

1. The licensee has failed to ensure that all registered staff had received orientation training before performing their responsibilities, including policies of the licensee that were relevant to the staff's responsibilities, and any other areas provided for in the regulations.

One RN indicated that they had not completed their orientation. A RN said they were unsure how to proceed with specific orders as they had not been trained. Errors were made related to the orders.

Documentation related to orientation shifts and training showed that one RN had not completed their orientation. They were also missing a training day.

The AS confirmed that a RN had missed the clinical training day and had not

completed their orientation fully before they were placed on the floor to work on their own.

The A-DOC acknowledged that they were short staffed when the incident occurred and they made the call to have the RN work on the floor by themselves. The A-DOC said that the home should have provided six shifts for new hires, two on each of days, evenings and nights and they did not.

Two written requests were made to the AS by the Inspector to provide a signed copy of the staff passport/checklist that demonstrated that nursing specific orientation related to RN/RPN roles and responsibilities was completed by four registered staff. In addition, a written request was made to inquire about the follow-up process related to orientation. No further response and documentation was provided by the AS or A-DOC.

The RAI-C said both RNs were new to the home and they had not been provided with education related to the specific orders. They acknowledged that the home's orientation checklist included this training. The RAI-C also indicated that the supervisory role at the home for education had not been in place.

2. The licensee has failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in palliative care annually.

During this inspection staff at the home raised concerns about the lack of direction and confusion surrounding palliative care.

When staff education was requested in relation to palliative care, the home did not provide any training records.

The home's education did not include information on palliative care.

Five registered staff all stated that there had been no training for palliative care provided at the home and they could not remember the last time that any training was done. The A-DOC was asked the last time palliative education was provided at the home and they said that they did not know.

3. The licensee failed to ensure that training in falls prevention and management was provided to all staff who provide direct care to residents.

O. Reg. 79/10, states that training in falls prevention and management shall be provided to all staff who provide direct care to residents.

A) The RAI-C said that the home recently changed their falls risk assessment tools. They said that it was rolled out in pieces through e-mail and staff were confused. They said initially the new assessment was not available in PointClickCare (PCC) and there was no plan on how the training would be tracked to ensure it was completed annually.

A RPN said that they knew very little about the home's falls program. There was a new policy but they had not seen it. They had received an email that indicated a new assessment tool was being used but they were not familiar with it. The RPN said the roll out of the new tool was ineffective and poorly organized.

The A-DOC said that they had been providing education in pieces to staff by e-mail. They said they believed the education provided was effective and that they were available to answer questions.

B) The RAI-C said that new equipment was ordered and that education was not provided to all PSW staff.

A document stated that due to many PSWs not attending the training, the equipment was taken off the floor. Eventually, the manual was placed on the floor for PSWs to read. The RAI-C said that all PSWs did not receive training. The A-DOC said that RAI-C would know what education was provided to the staff.

The home's education did not include the changes to the post fall assessment or information on how to use the new equipment.

The licensee failed to ensure that staff had been trained when there were changes to the home's falls prevention and management program.

4. The licensee failed to ensure that direct care staff were provided training in skin and wound care.

The home's policy and related documentation stated that registered staff were not required to complete weekly wound and skin care rounds and assess for wounds with other etiologies. Three registered staff all had different understandings of the direction that the skin and wound policy provided.

The home was unable to provide records related to the staff training on skin and wound care. The home's education related to skin and wound did not include the home's policy.

The RAI-C said that the training for registered staff was scheduled but was cancelled. A RPN said that they did not receive training on the skin and wound policy and that their training consisted of what they learned on the job. The Administrator said that training related to the skin and wound program was not completed.

Four staff and the Administrator identified different skin and wound program leads.

The licensee failed to ensure that direct care staff were provided training on the home's skin and wound policy and the skin and wound care processes required in the home.

The severity of the issue was a level 2, potential risk and the scope of the issue was a level 3, widespread. The home had compliance history of 2, multiple unrelated non-compliance. (728) (532)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Oct 25, 2019

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

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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Ordre(s) de l’inspecteur

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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 October, 2019 (A2)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by SHERRI COOK (633) - (A2)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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