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

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

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

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Oct 23, 2018	2018_722630_0019	023242-18	Resident Quality Inspection

Licensee/Titulaire de permis

Caressant-Care Nursing and Retirement Homes Limited
264 Norwich Avenue WOODSTOCK ON N4S 3V9

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

Caressant Care Woodstock Nursing Home
81 Fyfe Avenue WOODSTOCK ON N4S 8Y2

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

AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689), INA REYNOLDS (524), JULIE LAMPMAN (522), MELANIE NORTHEY (563)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 4, 5, 6, 7, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24 and 25, 2018.

The following Follow-up intakes were completed within this inspection:

Follow-up Log #017999-18 for Compliance Order (CO) #001 from Complaint Inspection #2018_508137_0017 related to the written policy and plan for hot weather and residents' heat risk.

The following Complaint intakes were completed within this inspection:

Complaint Log #007557-18 / IL-56470-LO related continence care, food quality, housekeeping services and the prevention of abuse and neglect.

Complaint Log #007602-18 / IL-56474-LO related to continence care, dining and snack services, falls prevention and residents' bill of rights.

Complaint Log #008204-18 / IL-56586-LO related to bathing care and sufficient staffing.

Complaint Log #008385-18 / IL-56645-LO related to food quality and dining and snack services.

Complaint Log #011759-18 / LTCH Complaint/Response related to the prevention of abuse and neglect.

Complaint Log #014091-18 / IL-57461-LO related to sufficient staffing and dining and snack services.

Complaint Log #020991-18 / IL-58921-LO related to sufficient staffing.

Complaint Log #021373-18 / IL-59049-LO and IL-59214-LO related to sufficient staffing and maintenance of mechanical lifts.

Complaint Log #024633-18 / IL-59700-LO related to skin and wound care, medication administration and the prevention of abuse and neglect.

The following Critical Incident intakes were completed within this inspection:

Related to the prevention of abuse and neglect:
Critical Incident Log #003540-18 / CI 2636-000009-18
Critical Incident Log #008956-18 / CI 2636-000020-18
Critical Incident Log #015355-18 / CI 2636-000026-18
Critical Incident Log #016171-18 / CI 2636-000029-18

Related to falls prevention

Critical Incident Log #029289-17 / CI 2636-000043-17
Critical Incident Log #000204-18 / CI 2636-000001-18
Critical Incident Log #001626-18 / CI 2636-000004-18
Critical Incident Log #005809-18 / CI 2636-000016-18

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the interim ED, the Director of Care (DOC), the Assistant DOC, Resident Care Co-ordinators (RCCs), the Environmental Services Supervisor, the Caressant Care Corporate Environmental Services Consultant, the Food and Nutrition Manager, the Administrative Assistant, Resident Assessment Instrument (RAI) Coordinators, the Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), Housekeepers, Maintenance staff, Cooks, Dietary Aides, Ward Clerks, Restorative Care Aides, family members and over forty residents.

The inspectors also observed resident rooms and common areas, observed medication storage areas, observed medication administration, observed meal and snack service, observed residents and the care provided to them, reviewed health care records and plans of care for identified residents, reviewed policies and procedures of the home, reviewed the written staffing plan of the home, reviewed staff schedules, reviewed various meeting minutes and reviewed written records of program evaluations.

Inspectors Meagan McGregor (#721) and Amberly Kerr (#435) were also present during this inspection.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Food Quality
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

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

- **24 WN(s)**
- **13 VPC(s)**
- **8 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the written plan of care for each resident set out clear direction to staff and others who provided direct care to the resident.

A) During an interview a staff member told Inspector #630 that they would know who to contact about a care decision through the profile in PointClickCare (PCC) where it stipulated who was to be contacted. The staff member said they thought that was set-up by someone in administration at admission. The staff member said that they could involve the resident in decision making if they were cognitively well and it depended on the resident.

During an interview a Resident Care Coordinator (RCC) said that the staff in the home would know whether a resident was making their own decisions or that there was a Substitute Decision Maker (SDM) through the Cognitive Performance Scale (CPS) score and by the contacts listed in the profile in PCC. The RCC said they were not sure who was responsible for setting up the PCC profiles in the home.

During an interview the Director of Care (DOC) said to determine if a resident was making their own decisions for care they would look at the CPS score, the Power of Attorney (POA) papers and whether the resident was able to answer questions for themselves. The DOC said that recently the Assistant Director of Care (ADOC) had

taken over the admission process. The DOC said that it was the expectation that this would be documented and care planned and this included the profile in PCC.

The clinical record for an identified resident did not clearly identify who was making care decisions for the resident.

During an interview a RCC said they were familiar with this identified resident. The RCC acknowledged that the clinical record for this resident did not clearly identify who was making care decisions. The RCC said that it was the expectation that the PCC profile would clearly show who was to be contacted for care decisions. (630)

B) The clinical record for another identified resident did not clearly identify who was making care decisions for the resident.

During an interview a staff member said they were familiar with this resident. The staff member said this resident had difficulties making care decisions for themselves and acknowledged that this was not clearly identified in the profile in PCC.

The licensee has failed to ensure that the written plan of care for these two identified residents set out clear direction to staff and others who provided direct care to the resident regarding who was involved in making the care decisions for the residents. (630) [s. 6. (1) (c)]

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

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding a fall for an identified resident.

Review of the clinical record for this resident showed that the resident required a specific type of care related to transfers and mobility. The plan of care indicated the resident used a specific device for mobility. A progress note and assessment report stated that this specific device had been removed from the resident's room and shortly after the resident sustained a fall.

During an interview a Registered Nurse (RN) said that they remembered the incident and that it occurred on a day when they were short of staff. The RN said the resident was left

in their room without their specific device and was not monitored. The RN said that when this device was removed from the room then the resident should have been monitored and should not have been left alone. The RN said that staff could also have replaced the device with another.

During a staff interview with a Resident Care Coordinator (RCC) said that an external service provider had removed the resident's device from their room for cleaning and staff were not aware. The RCC agreed that if a resident required their ambulation device as per plan of care then it should have been readily available.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. (524) [s. 6. (7)]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10, s. 20 (1) states, "Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-

based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat."

On July 16, 2018, during complaint inspection #2018_508137_0017, compliance order (CO) #001 was issued and ordered the licensee to take action to achieve compliance by ensuring that the home's policies "Hot Weather Plan –Staff", "Hot Weather Plan – Residents" and "Hot Weather Plan – Taking Humidity and Temperature Readings – Residents" were complied with. This order was to be complied on July 31, 2018.

CO #001 issued in inspection #2018_508137_0017 stated:
"The licensee must be compliant with O.Reg.79/10, s.8 (1)(b).
Specifically the licensee must:
a) Ensure that staff receive an in-service of the hot weather plan and to include but not limited to the signs and symptoms of heat stress, causes, risk factors, controls and preventions.
b) Ensure that all residents have a completed and updated heat assessment on file.
c) Ensure the documentation is completed on the Humidex recording forms, at the start of each shift, and that daily monitoring takes place to ensure the process is being followed."

A review of the home's Hot Weather Plan – Residents and Staff dated July 2018, noted the following:
"The Hot Weather Plan will be in effect from May 1 to September 30 or during periods of high temperature reading (35 C) and high humidity levels.
Registered staff are responsible for taking the readings each hallway (Resident Areas).
Procedure for taking and recording Humidex:
Purpose: Timely detection of Humidex 30 or greater. Hourly recordings when Humidex is above 34 or the temperature is above 25 C."

The home's Hot Weather Plan In-service stated, "The temperature and relative humidity is taken and recorded at the beginning of each shift by the registered staff in each hallway section of the Nursing Home and hourly by the staff working in the high risk areas (tub/shower rooms, laundry room, dishwasher rooms and kitchens)."

A) Review of the home's Hot Weather Plan - Indoor Humidex Recording Forms for August and September 2018, identified that the readings for temperature, humidity and humidex were not recorded for multiple areas in the home at multiple times in accordance with the home's policy and procedures.

During an interview a RPN stated that registered staff were responsible to record the temperature and humidity each shift and record it on the Humidex Recording form. The RPN stated if the temperature or humidity got too high then registered staff recorded the readings hourly.

During an interview, a Resident Care Coordinator (RCC) stated that registered staff were responsible for monitoring and recording the temperature, humidity and humidex on the resident home areas. The RCC reviewed the humidex recording forms and confirmed that registered staff were not consistently documenting the temperature, humidity and humidex each shift and hourly when the temperature was above 25 degrees Celsius.

During another interview a Resident Care Coordinator (RCC) stated the RCCs were to audit completion of the humidex recording forms. RCC stated they were to go around and check that staff were completing the forms but this was not documented. The RCC stated that they needed to start doing the audits and documenting that the audits were completed.

B) During interviews two identified staff stated they had just returned back to work and had not received any education on the home's Hot Weather Plan.

Review of the home's Hot Weather Plan training records noted that 11 out of 166 (6.6%) staff had not completed the Hot Weather Plan training.

During an interview the interim Executive Director (ED) stated all staff should have received training and that staff should be following the home's Hot Weather Plan policy.

The licensee has failed to ensure that the "Hot Weather Plan –Staff", "Hot Weather Plan – Residents" and "Hot Weather Plan – Taking Humidity and Temperature Readings – Residents" were policies were complied with as required in CO #001 from Inspection #2018_508137_0017 with compliance due date July 31, 2018. (522) [s. 8. (1)]

Additional Required Actions:

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

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

During an interview a family member told Inspector #563 that an identified had developed multiple wounds after their admission to the home.

The clinical record for this identified resident showed that this resident had developed multiple wounds of a specific type since their admission to the home. The care plan in Point Click Care (PCC) documented to turn and re-position this resident every two hours and the resident required a specific type of assistance with bed mobility.

During an interview the RAI Coordinator provided the "Caressant Care Woodstock Documentation Survey Report v2" for a specific time period and stated that the times for PSW documentation were from 0000 hours (midnight) to 2200 hours each day and if there were blanks in documentation that it would mean that there was no documented evidence that the task was completed for repositioning every two hours.

The "Caressant Care Woodstock Documentation Survey Report v2" for this resident had the care plan task to turn and re-position resident every two hours. The Personal Support Workers (PSWs) were to document the care provided in PCC Point of Care (POC). The resident was not documented as being turned and reposition for identified time periods over the course of five months.

During an interview the Director of Care (DOC) acknowledged that this resident had multiple wounds that had been acquired in house after admission. The DOC stated the resident was on a turning a repositioning routine every two hours since admission. The DOC looked at the "Caressant Care Woodstock Documentation Survey Report v2" for each month and acknowledged that there were multiple blanks in documentation and the PSWs did not document the completion of the task.

Based on interviews and record review, the resident was dependent on staff for repositioning every two hours related to skin integrity concerns. There was no documented evidence that the resident was turned and repositioned every two hours and the resident acquired wounds. (563) [s. 50. (2) (d)]

Additional Required Actions:

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

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 87. Housekeeping

Specifically failed to comply with the following:

s. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,
(a) cleaning of the home, including,
(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and
(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces; O. Reg. 79/10, s. 87 (2).
(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:
(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,
(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and
(iii) contact surfaces; O. Reg. 79/10, s. 87 (2).
(c) removal and safe disposal of dry and wet garbage; and O. Reg. 79/10, s. 87 (2).
(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee ensured that procedures were developed and implemented for cleaning of the home, including resident bedrooms, floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas including floors, carpets, furnishings, contact surfaces and wall surfaces; and the cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

A) During the Resident Quality Inspection (RQI) initial tour, there were multiple common areas of the home which were observed to be unclean.

During an interview a Maintenance staff member and Environmental Service Supervisor (ESS) verified that the whirlpool room was unclean. The ESS stated it was the expectation that the whirlpool area was cleaned every day. The ESS stated that the housekeepers were responsible for cleaning the tub room floors once a day on the day shift, but was unsure who was responsible for cleaning the shower walls since nursing staff were responsible for the tubs. The ESS was also unsure how often the shelving units were cleaned, but verified that both shelving units should be moved and cleaned underneath. The ESS stated the whirlpool tub closet was to be cleaned and acknowledged that the floors were not clean.

During an interview the Director of Care (DOC) observed the whirlpool tub closet area and verified that there were cobwebs and that the floor needed to be cleaned. The DOC also verified that there was a brown build up on walls and floor in shower stall areas.

During an interview the ESS and Inspector #563 observed the adjacent brick wall and flooring adjacent to the whirlpool tub room. The ESS verified that there were cobwebs and that the floor needed to be cleaned. The ESS stated they just recently acquired the housekeeping department as part of their responsibilities. The ESS was asked if there was a housekeeping audit in place to ensure common areas and resident rooms were being cleaned as scheduled and they said they did not know.

The Caressant Care Nursing & Retirement Homes Ltd. "Cleaning Guidelines – Tub Rooms" policy last reviewed August 2017 stated: "All tub rooms shall be thoroughly cleaned daily." The procedure included that housekeeping was responsible for wiping grab bars, pull cords and shower control with a disinfectant, to clean the outside of the tub and to dry/wet mop the floors.

The Caressant Care Nursing & Retirement Homes Ltd. "Cleaning Guidelines – Common/General Areas" policy last reviewed August 2017 stated: "Dry and/or damp mop or use Auto Scrubber to clean hallways daily."

During a follow-up interview the ESS stated the expectations for cleaning of the tub/shower/whirlpool areas was done by housekeepers and that they had been just cleaning the floors and a cleaning routine for a weekly spray down would be implemented and completed by housekeepers. The ESS stated cleaning resident rooms

was done daily and the expectation for cleaning hallway floors, walls, hand rails and surfaces was that they were done once a week. The ESS also stated that ceiling and wall vents were vacuumed and cleaned for dust twice a year.

The Environmental Service Supervisor (ESS) toured the home, including resident rooms and common areas, with Inspector #563 and Inspector #721 and the ESS acknowledged multiple areas in the home which were not clean. The ESS acknowledged that there were multiple privacy curtains in residents' rooms which were not clean. The ESS acknowledged that an identified mechanical lift was not clean.

The Caressant Care Nursing & Retirement Homes Ltd. "Cleaning Guidelines – Thorough Cleaning" policy last reviewed August, 2017, stated: "all areas of the facility must be thoroughly cleaned as per schedule." The procedure included stripping, re-waxing floors (if required) and buffing as per schedule, cleaning of inside windows, washing walls, ceilings (where possible), the removal of laundering of window curtains and privacy curtains (semi-annually or as per schedule) and thorough dusting high and low. This included washroom area as well when cleaning the resident's room.

The Caressant Care Woodstock's "Level 1 & 2 Assigned Room Clean" documented specific tasks that were to be done on an eight week rotation.

During an interview with Housekeepers they stated on a daily basis resident rooms were cleared of garbage, dusted, bathrooms including toilet, counter, sink, and mirror were cleaned and resident room and bathroom floors were washed. They stated that walls were included in the total clean of a resident's room which was done approximately every two months, otherwise it was a spot cleaning of the walls. The housekeepers stated that privacy curtains were taken down when soiled and sent to laundry, but there was no schedule for this task. They shared that the floors were mopped daily, and then a couple of days a week they used the auto scrubber and there was no routine for when the floors were cleaned with the auto scrubber. The housekeepers stated that there were four housekeepers in the home for the day shift and one student in the evening. The housekeepers verified that they cleaned the whirlpool room floor, but that the nursing staff providing the baths were to clean the shelves and everything else.

The Caressant Care Nursing & Retirement Homes Ltd. "Principal Functions" policy last reviewed August, 2017, stated the "housekeeping department cleans all residents rooms, common areas e.g. lounges, hallways, dining rooms, utility rooms, offices, as per the daily routine."

The Caressant Care Nursing & Retirement Homes Ltd. "Job Description – Housekeeping Aide" policy last reviewed May, 2017, stated, "The Housekeeping Aide is responsible for maintaining high standards of cleanliness and sanitation throughout the facility by adherence to established work schedules, and in accordance with governmental and facility guidelines". The primary duties and responsibilities for the housekeeping aide included performing "tasks such as: stripping/waxing/buffing of floors, vacuuming, sweeping, dry/wet mopping, scrubbing, sanitizing/disinfecting floors, furniture, shelves, woodwork, bathroom fixtures, spot cleaning walls, windows and doors between washing, dusting emptying wastebaskets and rearranging furniture, replenishing supplies, cleaning utility rooms, closets etc."

The Caressant Care Nursing & Retirement Homes Ltd. "Cleaning Guidelines – Wet Mopping Floors" policy last reviewed July, 2017, stated: "All floor areas must be kept clean and free of all hazards".

During a follow-up interview the ESS acknowledged that the "Cleaning Guidelines – Tub Rooms" did not make reference to who was responsible for cleaning the tile walls in the shower areas. The ESS stated the tile walls in the tub rooms should be cleaned by the housekeeping staff, but did not know how often this would be done. The ESS stated that there were established work routines and policies for housekeeping, but that there were areas in resident rooms, hallways and tub rooms that had a build-up of dirt and debris. The ESS was asked about the "Cleaning Guidelines – Thorough Cleaning" policy last reviewed August, 2017, which stated: "stripping, re-waxing floors (if required) and buffing as per schedule". The ESS stated they were not aware of any schedule for this task.

During an interview the Corporate Environmental Services Consultant (CESC) stated it was the responsibility of the CESC, the Regional Manager, the Executive Director (ED) and the ESS to ensure housekeeping staff were completing their routines as outlined, that the home was clean and to follow up with staff to ensure those expectations were being met. The CESC verified it was the responsibility of the housekeeping department for the cleaning of the tiled shower stall walls and whirlpool room. The CESC stated the "Monthly Housekeeping Audit" was not new and has been in effect for a while and was previously completed by the ED, but the ESS was now responsible for its completion. The CESC did not know when the last housekeeping audit was completed. Inspector #563 and the CESC reviewed the home's policy titled "Housekeeping Audit" policy with last reviewed September 2018. The policy stated: "should trends develop or are noted, note which area to determine if there is a problem with staff or a procedural problem that

requires housekeeping in-service." The CESC stated the ESS was responsible for following up with staff and the CESC was responsible for providing the housekeeping in-service. The CESC verified that an in-service had not been provided. The CESC also stated that when they were present in the home they subtlety watch one or two housekeepers clean a resident room, but there was no documentation of this housekeeping inspection.

During a follow-up interview the ESS stated that there was no housekeeping audit done and they thought that the monthly housekeeping audit was newly implemented. During an interview the Executive Director (ED) stated the home could not locate the last housekeeping audit completed. The ED stated that in speaking with ESS they believed the audit was not done. (563)

B) During stage 1 of the RQI multiple residents by multiple inspectors were observed to have unclean ambulation equipment.

During follow-up observations five identified residents were observed by Inspector #563 to have unclean ambulation equipment.

During an interview with a PSW they acknowledged to Inspector #563 that these residents had unclean ambulation equipment.

The clinical record for two of the identified residents did not include cleaning of the ambulation equipment. The clinical record for two other of the identified residents indicated that staff had documented that they had cleaned the ambulation equipment within the past week. The clinical record for one other of the identified residents indicated that the staff had documented that they had not cleaned the ambulation equipment when it was scheduled.

During an interview the Director of Care (DOC) stated the cleaning of resident ambulation equipment was done by PSWs on the night shift, and that there was a routine and job description for that. The DOC stated that each wheelchair should definitely be wiped down each night with a Virox wipe and verified that the cleaning of ambulation equipment did include the wheels, foot rests, cushions and head rests. The DOC verified that two of the residents did not have a routine for cleaning as part of their plan of care. The DOC stated there was POC documentation that one of the identified residents just had their ambulation equipment cleaned. The DOC and Inspector #563 then observed this resident's ambulation equipment for a build-up of debris and dust on wheels, brakes,

and armrests. The DOC verified the ambulation equipment was not cleaned as documented for this resident. The DOC also verified that the ambulation equipment for three identified residents were not cleaned and had a build-up of dirt and dust.

The Caressant Care Nursing & Retirement Homes Ltd. "Commodes, Wheelchairs, Lifts – Cleaning Guidelines" policy last reviewed June, 2018, stated: "All equipment will be cleaned and well maintained. All wheelchairs, walkers, gerichairs, lifts & shower chairs are to be cleaned weekly by the PSW's". The procedure in this policy stated, "resident's with personal seat covers are to be removed, sent to laundry for washing, air dried and reapplied before morning."

Based on observations, staff interviews and record review of policies and procedures related to housekeeping, the licensee failed to ensure that procedures were implemented for cleaning of the home. The Environmental Service Supervisor acknowledged multiple resident bedrooms, bathrooms, floors, privacy curtains, contact surfaces and wall surfaces were not clean. The Director of Care acknowledged five residents had ambulation equipment and positioning aids that had a build-up of dirt, dust and debris and were not cleaned. The DOC also acknowledged that for two of the five residents, the cleaning of their ambulation equipment was not a part of their plan of care. (563) [s. 87. (2)]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that, (b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(a) electrical and non-electrical equipment, including mechanical lifts, are kept in good repair, and maintained and cleaned at a level that meets manufacturer specifications, at a minimum; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance.

A) During Stage One of the RQI, Inspectors #563, #689 and #721 noted disrepair in resident rooms and bathrooms. The Environmental Service Supervisor (ESS) toured the home on a specific date, including resident rooms and common areas, with Inspector #563 and Inspector #721 and the ESS verified that there were multiple areas of disrepair in common areas and resident rooms.

During an interview the Environmental Service Supervisor (ESS) verified that there were no schedules and procedures in place that they were aware of for remedial maintenance of walls, floors and bathrooms. The ESS verified that a room audit for maintenance disrepair was not being completed at this time and acknowledged they were unaware of the disrepair in the home at this time, other than what was in the Maintenance Care online reporting system. The ESS verified that all staff had access to the reporting system, but that staff do not report all areas of concern and therefore the ESS did not know about them. The ESS stated that previous Executive Directors had completed the resident room audits, but the ESS was unable to locate the documentation.

During a follow-up interview the Environmental Service Supervisor (ESS) stated that quarterly each resident room was reviewed for painting or repair needs and acknowledged and that the Corporate Environmental Service Consultant would be

completing this. The ESS stated a schedule was just created in Maintenance Care for the painting of resident rooms and common areas. The ESS verified that there was no schedule as part of the preventative maintenance program for remedial maintenance related to painting and drywall repair before the day of the interview. The ESS stated the new biweekly general room repair schedule included common areas that would be done quarterly. The schedule did not include hallways, but lounges, kitchens and dining rooms have been added.

During an interview the Corporate Environmental Services Consultant (CESC) stated the home was ensuring areas of disrepair were being addressed by developing an action plan and completed quarterly. The CESC stated they looked at baseboards, wall damage, sinks that need to be repaired, and toilets that needed to be caulked for example. The CESC stated that the home did conduct their own inspections or audits of resident rooms quarterly and were completed by the CESC for all resident rooms. The document titled "Caressant Care Preventative Maintenance Program Resident's Rooms/Common Areas Action Plan" was reviewed and the CESC stated the form was used to support the "Preventative Maintenance Program for Resident's Rooms / Common Areas" policy. The CESC stated the form was last completed in August 2018. The document asked for the room number, item to be addressed and who it was reviewed by. The CESC was asked what was done with the information collected after the completion of the audit in August 2018 and they replied that the document was scanned and sent to the Executive Director by email. The document was then supposed to be reviewed by the Executive Director and tracked to ensure the work was completed and for follow up with the maintenance staff. The CESC acknowledged that the August Action Plan for preventative maintenance of resident rooms / common areas was not dated or documented as reviewed by anyone. The Corporate Environmental Services Consultant (CESC) stated they were now responsible for doing the quarterly maintenance inspections.

During an interview the Executive Director (ED) verified that the quarterly Action Plan for August was never provided to them and the ED had not reviewed it and does not have a copy of it. The ED was unsure if the previous quarterly Action Plan was completed for May 2018.

Based on observations, staff interviews and record review of policies and procedures related to the preventative maintenance for resident rooms and common areas, the licensee failed to ensure that there were schedules in place for remedial maintenance. (563)

B) Complaint #IL-59214-LO was submitted to the Ministry of Health and Long-Term Care (MOHLTC) which stated residents were not getting the care that they need as there was broken equipment such as lifts, and they were not being repaired or replaced.

Review of the home's Preventative Maintenance of Mechanical Lift policy, reviewed date August 2017, noted the following:
Maintenance Staff shall:
1. Maintain all equipment in safe operating condition.
2. Complete monthly lift inspection and document using the Lift Inspection Log
3. Ensure an annual lift inspection is completed by a qualified contractor.

A review of the home's repair logs for mechanical lifts noted that there was no documented evidence to support that mechanical lifts were being inspected monthly.

During an interview the Environmental Services Supervisor (ESS) acknowledged that not all mechanical lifts were inspected monthly. The ESS stated that most lifts come down for maintenance monthly so they saw most lifts. When asked if there was a schedule in place to ensure all lifts were inspected monthly, the ESS stated that there was no schedule in place for monthly inspections of mechanical lifts.

During an interview the Interim Executive Director stated that all mechanical lifts should be inspected monthly and there should be a schedule in place for monthly inspections of mechanical lifts.

The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for routine, preventive and remedial maintenance. (522) [s. 90. (1) (b)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications, at a minimum.

Complaint #IL-59214-LO was submitted to the MOHLTC which stated residents were not getting the care that they need as there was broken equipment such as lifts, and they were not being repaired or replaced.

Review of the home's Preventative Maintenance of Mechanical Lift policy, reviewed date August 2017, noted the following:
Maintenance Staff shall:
1. Maintain all equipment in safe operating condition.
2. Complete monthly lift inspection and document using the Lift Inspection Log
3. Ensure an annual lift inspection is completed by a qualified contractor.

A) During an interview the Environmental Services Supervisor (ESS) stated that the home had 24 lifts in service in the home. The ESS stated that from June 2018, until present there had been 23 lift repairs. When asked how long each lift was out of service during the repairs, the ESS was unable to determine how long each lift was out of service. The ESS stated that the home used an electronic system called Maintenance Care for staff to enter mechanical lift repairs. The ESS stated maintenance may have completed a repair in a day but the work order may not be closed off in Maintenance Care for several days so there was no way to determine how long a lift may have been out of service. The ESS also stated that repairs were still hand written in the lift repair log and if the repair was documented in the lift repair log maintenance did not track the length of time the lift was out of service.

A review of the home's repair logs for mechanical lifts noted that there was no documented evidence to support that mechanical lifts were being inspected monthly.

During an interview the ESS acknowledged that not all mechanical lifts were inspected monthly. The ESS stated that all lifts in the home received an annual inspection in May 2017, from Care-Med Health Systems.

B) A review of the home's annual lift inspections noted that there were six lifts that did not have an annual lift report from Care-Med Health Systems. The ESS stated if there was no annual report there would be a maintenance inspection sticker on the lift to show there was an annual inspection of the lift in 2017.

During an interview the ESS and Inspector #522 reviewed the lifts on the floor to determine if there was a maintenance inspection sticker from Care-Med Health Systems on the lifts. During this interview it was observed that multiple lifts did not have an inspections sticker on them or the inspection sticker was illegible. The ESS and a maintenance staff member reported that there were three lifts out of service at the time of the interview. The ESS said they did not know how long one of the lifts had been out of service. The ESS also said that there was one lift that was listed that had been replaced

with a new lift and therefor they thought that lift did not require an annual inspection. The ESS stated that when the lift was replaced they kept the same lift number and service log as the previous lift. Inspector #522 asked when the lift was replaced and the ESS stated they did not know but thought it was within the year. There were no notes in the service log or the maintenance lift tracking sheet to support that the lift was replaced.

C) During an observation in a specific area, Inspector #522 observed a lift with a maintenance inspection sticker from Care Med Health Systems. The area for date and initials was blank. A maintenance staff confirmed there was a sticker on the lift but there was no date or initials.

A review of the annual lift report from Care-Med Health Systems for this lift noted the lift had failed inspection on in May 2017. A review of the repair log for the lift noted an entry in September 2016, which noted that the rear castors were replaced and no further repairs noted until October 2017, which noted the emergency stop button was replaced. There were no noted repairs after the annual inspection noted the lift had failed inspection.

During an interview Inspector #522 asked the ESS why this lift had failed inspection, what repairs were completed and how long the lift was out of service. The ESS was unable to provide this information. The ESS stated that the lift was repaired since it was currently being used.

During an interview the interim Executive Director (ED) stated that all lifts should be inspected monthly and have an annual inspection on the anniversary of the previous inspection. The interim ED stated that the lift that was put into service in January 2017, should have had an annual inspection. The interim ED stated that the completion of service and repairs on lifts needed to be documented appropriately.

The licensee has failed to ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications, at a minimum. (522) [s. 90. (2) (a)]

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. 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 :

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

A) A Medication Incident - Original Report for an identified resident documented that Medical Pharmacies had received a fax which was not processed regarding the order to hold a specific medication for a specific amount of time. The original order dated was never received by the pharmacy and the facility staff did not follow up on a new order to ensure it had been processed. Pharmacy was unaware that the order existed until a fax was received three days later.

The Caressant Care Nursing Home Woodstock - 2018 Medication Error Analysis documented the physician faxed to hold the medication then decrease the dose. The night nurse faxed this to pharmacy but the order was not processed. As a result, the change was not entered into the electronic Medication Administration Record (eMAR). Pharmacy called to alert the nurse of the error and the nurse faxed a new order, but did not put note on the strip package to alert others of the change in dosage of this medication.

The "Fax Cover Sheet" from the physician documented that this medication was to be held and then restarted at a different dose.

The eMAR for documented that this identified resident was administered the medication by mouth at a specific dose daily during the three days after the physician had ordered it

to be held.

The "Fax Cover Sheet" from the physician documented that they had sent fax to hold the medication but pharmacy not aware. The physician advised that the medication was then to be held for a specific time period and then restarted at a specific dose.

The eMAR then documented that this resident was not administered the medication for three days and then was administered to the resident at a different dose then had been ordered by the physician.

During an interview the Director of Care (DOC) verified that the medication was not held as had been ordered and the order was not administered in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that the medication was administered to this resident in accordance with the directions for use specified by the prescriber.

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

The Infoline - Complaint Information Report #IL-59700-LO documented complaints related to the care of an identified resident. The complainant reported concerns regarding the administration of a specific medication.

The electronic Medical Directives Record (eMDR) for a specific time frame directed that a specific type of test was to be done as needed. There was no documentation that this testing had been completed for this identified resident.

The electronic Medication Administration Record (eMAR) in PCC for specific time frames showed that the specific medication had not been administered as per the physician's orders.

During an interview the Director of Care (DOC) stated the order for the specific test meant the nurses could do the test like an as needed (PRN) order. The DOC stated that there was no documentation of this testing having been done for a specific time period. The DOC also acknowledged that the specific medication for this resident had not been given as prescribed on specific dates.

The licensee failed to ensure that this specific medication was administered to this identified resident in accordance with the directions for use specified by the prescriber. (563) [s. 131. (2)]

Additional Required Actions:

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

O. Reg. 79/10, s. 31 (2) states that every licensee shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

O. Reg. 79/10, s. 31 (3) states that 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 (4) states that the licensee shall keep a written record relating to each evaluation under clause (3) (e) 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.

Specifically the licensee did not comply with the following:
- The home's staffing plan with documented implementation date May 2018.
- The home's policy titled "Staffing Plan/Reassignment of Duties" with effective date February 2018 and reviewed date February 2018.
- The actions and plans identified in the Caressant Care "Quality Program Evaluation NSGPSW Staffing Plan" dated November 14, 2017.

The Home's written "Staffing Plan" dated August 2018 indicated the following staffing levels for 163 residents:
- PSWs: 18 total for day shift per day; 12 total for evening shift per day; 8 total for night shift per day; total 38 per 24 hours period.
- RPNs: 3 total for day shift per day; 3 total for evening shift per day; 1 total for night shift per day; total 7 per 24 hours period.
- RNs: 3 total for day shift per day; 2 total for evening shift per day; 1 total for night shift per day; total 6 per day.

The home's policy titled "Staffing Plan/ Reassignment of Duties" with effective date February 2018 and reviewed date February 2018. This policy included:
- "Caressant Care will ensure that staffing levels are effective so that each resident will receive individualized personal care, including hygiene care and grooming on a daily basis."

- "If the home is required to work short the registered staff will reassign/prioritize duties as needed."
- "When possible the home will reschedule any missed shifts to catch up on any duties that did not get completed on the previous shift for example bath shifts."
- "Appendix One: Vacant Position: PSW/HCA; Vacant Shift: Days and Evenings; Plan Strategy: Call all available PSW/HCAs, bring staff in early to stay late, reassign staff i.e. bath shift to regular shift, reassign residents to available PSWs; Duties that must be done: ADL's, baths, POC documentation, feeding in the dining rooms and distribution of snacks."
- "Low Staffing Shift Routine Guidelines" included "Priorities: 1. Safety rounds every hour are top priority; 2. Checking, changing and toileting; 3. Getting residents to and from meals and feeding; 4. Answering callbells."

The "Quality Program Evaluation NGSPSW Staffing Plan" dated November 14, 2017, included:
- "Summary of changes made over the past year: Implementation of Attendance Management and Performance Management."
- "Were program objectives met? No"
- "List of Actions/Areas of Improvement" included "enhanced focus on recruitment and retention; orientation program; ensuring vacancies are filled as they become vacant; continued consultation with VP or HR regarding potential schedule changes in 2018."
- "If needed has an action plan be developed? N/A"

During an interview the DOC provided a summary of the staffing shortages for July, August and September 2018. These summaries showed the following staffing shortages:

Personal Support Workers (PSWs):
- 59 partial shifts short and 24 full shifts short with 28/31 calendar days short at least one PSW staff for July 2018.
- 84 partial shifts short and 63 full shifts short with 30/31 calendar days short at least one PSW staff for August 2018.
- 30 partial shifts short and 14 full shifts short with 16/17 calendar days short at least one PSW staff for September 2018.

Registered Practical Nurses (RPNs):
- 6 partial shifts short and 4 full shifts short with 10/31 calendar days short at least one RPN staff for July 2018.
- RPNs: 5 partial shifts short and 12 full shifts short with 10/31 calendar days short at

least one RPN staff for August 2018.
- RPNs: 0 partial shifts short and 3 full shifts short with 3/17 calendar days short at least one RPN staff for September 2018.

Registered Nurses (RNs)
- 1 partial shifts short and 13 full shifts short with 14/31 calendar days short at least one RN staff for July 2018.
- 2 partial shifts short and 18 full shifts short with 15/31 calendar days short at least one RN staff for August 2018.
- 4 partial shifts short and 9 full shifts short with 9/17 calendar days short at least one RN staff for September 2018.

A) The Ministry of Health and Long-Term Care (MOHLTC) received complaint log #008204-18 which identified an anonymous concern that a specific resident did not receive a bath or shower for nine days and that the resident was told that the staff did not have time to provide that care.

During an interview this resident told Inspector #630 that there was a specific period of time after they moved into the home when did not receive a bath or shower. This resident said they did have a concern about the bathing care that they were receiving in the home and that it seemed that there were not enough staff available to provide the care needed. This resident said they had a specific preference related to the type of bathing care they received.

During an interview a PSW said they were familiar with this resident. This PSW said that it was expected that residents would be provided with two baths or showers per week. The PSW said they document in Point of Care (POC) when a resident has been given a bath or a shower and whether a resident had refused that care. The PSW said that this resident preferred to have a specific type of bathing care and required assistance from staff with bathing care.

The clinical record for this resident showed that the first documented shower that resident received in the home was 14 days after admission, the first documented bed bath that the resident received in the home was 17 days after admission and the first documented tub bath that the resident received was 22 days after admission. The plan of care for this resident identified they preferred a specific type of bathing care. The Point of Care (POC) report for specific time periods showed that this resident had not received their preferred type of bathing care five out of 22 of their designated bathing days.

During an interview a RCC told Inspector #630 that it was the expectation in the home that residents would receive two baths or showers per week of their preferred type and their preferred time in terms of days or evenings. The RCC acknowledged that the home had been working without the full complement of PSW staff over the past three months and that they had been trying to ensure the residents had been receiving their required bathing care during that time. The RCC and Inspector #630 reviewed the POC documentation for this resident and the RCC acknowledged that there was a fourteen day period after admission where this resident did not receive their preferred bathing care as per the documentation. The RCC said that it was the expectation in the home that documentation would be completed to reflect the care provided and that they told staff that if it was not documented then it was not completed.

B) The MOHLTC received complaint log #021373-18 which identified a concern regarding short staffing in the home. This complaint said that there were residents in a specific area of the home who were not getting the care that they wanted due to lack of staffing.

The MOHLTC received complaint log #014091-18 which identified a concern regarding short staffing in the home. This complaint said that there was a regular shortage of staff including registered nursing staff and there residents were "suffering."

During an interview Inspector #630 spoke with the complainant who indicated they were a staff member who wished to remain anonymous. This complainant said that it was hard to get the residents' care done when they were working short. The staff member said that usually there were three PSWs on the shift and there had been multiple times when there were only two staff. The staff member said it was affecting the residents as they tried their best and work the entire shift to try to make sure residents are getting the care they needed but it was affecting toileting and the feeding assistance provided to residents. The staff member said that they thought the management in the home were aware of the concern. The staff member said that the home had been offering overtime but no one wanted to work overtime when the home was short as it was like doing double the work.

C) The MOHLTC received complaint log #020991-18 which identified a concern regarding chronic understaffing and that the residents were not being treated well. This complainant indicated that the "LTC administration are aware of the issue but administration had not tried to resolve the issue due to short staffing."

During an interview with a family member for an identified resident they expressed they had concerns with staffing levels in the home. The family member said that they did not think there were enough PSWs to care for the residents. The family member said that staff were rushed with bathing and there were residents, including their family member, who were not receiving their baths. This family member said they had brought forward this concern to the management and Corporate management for the home. The family member said that they received a response from the CC Director of Regional Operations who indicated they were trying to hire more staff and that there was a PSW shortage. The family member said they were not satisfied with the response to the concern as they thought that nothing had really improved. The family member said that the staff in the home worked very hard and were "really good" and "kind" but they were concerned and saddened by the shortages and other families have expressed concerns as well.

During an interview the interim Executive Director (ED) provided a written letter from a family member for an identified resident with a specific date. This letter identified concerns with the staffing shortages in the home. The interim ED also provided a written letter of response from the CC Director of Regional Operations and this letter stated "the home has been experiencing some staffing shortages due to some vacant lines and staff vacation." This letter also stated "the home is also reviewing the staffing pattern to ensure there is adequate staff on the floor at all times. The home recently created some permanent fulltime lines and are in the process of reviewing the job duties to ensure that the residents care needs are all met."

During an interview a PSW said that this identified resident required a specific level of assistance from staff with care. The PSW said that it was the expectation in the home to document the care provided to residents and if a resident refused care that would be reported and documented. The PSW said that this resident did refuse care from staff four to five times a week and they would try to reapproach.

The clinical record for this identified resident showed that they required specific types of assistance from staff with care. The Point of Care "Documentation Survey Report v2" for this resident showed that for specific time periods there were specific types of care that were not documented as having been completed.

During an interview the Director of Care (DOC) told Inspector #630 that they had started working in the home and in the DOC position recently. The DOC said that the home had needed to use the staffing back-up plan over the past three months related to staff

shortages for PSWs, RPNs and RNs. The DOC said that the expectation in the home was that the staff were following the "Staffing Plan/Reassignment of Duties" when working short and it was the expectation was that care would be provided as per the residents' care needs as outlined in the plan. The DOC said that it was the expectation in the home that documentation of the care provided would be completed. When asked if the staff had been able to complete the required documentation on residents as part of their shifts, the DOC said absolutely not and that it had been an ongoing issue before they started in the role. The DOC said that they if care was not documented then it was not considered to be done.

During an interview a Registered Nurse (RN) told Inspector #630 that there had been times in the past three months when the home had been working short PSW and registered staff. The RN said that the home had been very short staffed at times and three to four times a week they were working short PSWs. The RN said that they the management was doing their best to try to hire more staff. The RN said that when they were short staff they would need to move staff around in the home and management and other disciplines would help pitch in to care for the residents. The RN said they thought there was a policy on how to manage the back-up plan at the ward clerk's desk. The RN said that it was hard when they were working short as the residents were vulnerable and the staff did their best to meet their care and safety needs. The RN said that when they were working with a full complement of staff then they felt they were able to meet the care needs of the residents.

During an interview the interim Executive Director (ED) told Inspector #630 that they had just started in the role the day before on an interim basis. The interim ED said that they had not personally been involved in responding to the letter but did have a copy of the letter and had reviewed this documentation. The interim ED said that in the letter of response the CC Director of Regional Operations acknowledged in the letter that the home had been short staffed and that they we retaking actions to hire new staff and review the job duties. The interim ED said the home had been short staffed over the summer.

D) During Stage one of the RQI the family member for an identified resident said that they were concerned that the home was short staffed all the time and that their family member had to wait for assistance from staff regularly during a specific time period. The family member told Inspector #630 that they visited the home regularly and provided assistance to the resident and required assistance from staff with specific types of care for this resident.

The clinical record for this resident showed that they required specific types of care from staff. The Point of Care "Documentation Survey Report v2" for this resident for a specific time period showed that specific types of care had not been documented as having been completed.

During an interview a PSW said that this resident's family had requested assistance with specific types of care for this resident. The PSW said that the resident required assistance from staff. The PSW said that they had concerns with staffing shortages in the home. The PSW said that when fully staffed each wing had an average of nine to ten residents per PSW for care. The PSW said it was difficult to getting the residents up, portering to meals and doing morning and most residents required two staff for assistance.

During an interview the Director of Care (DOC) said that it was the expectation in the home that residents would be positioned at least every two hours in the home for offloading and to prevent skin breakdown and this reposition was to be documented by the PSWs in PCC. The DOC acknowledged to Inspector #630 that it was difficult to determine if repositioning had been done for this resident based on the documentation in PCC.

During an interview another PSW told Inspector #630 that there have been times in the past three months when they have been working short staffed. When asked what the staff would do when working short do determine how to manage the shortage, the PSW said they would talk among themselves and try to go where the need was higher. The PSW said there was no set plan on what to do when they were short. The PSW said that when they were short they tried to ensure that all the care was provided to residents but they did not always have time to complete the charting and sometimes residents had to wait for care or wait for the lift.

E) During an interview a PSW said that they would know what care a resident requires with dental care by the plan of care and asking the resident. The PSW said they were familiar with an identified resident and that this resident required a specific type of assistance from staff to clean their teeth. This PSW also told Inspector #630 that this summer the home had been short staffed and it had been hard to keep up with the demands of the resident. The PSW said that lot of staff had been working time and a half and double time and they were having a hard to get the charting done. The PSW said they thought that the bare necessities of care were getting done. The PSW said the

home had been short registered nursing staff as well as PSWs. The PSW said that sometimes they had been short two staff on a shift and working with one modified and the modified would do tasks like the nourishments. The PSW said that sometimes that meant there were two PSWs for 42 residents and resident having to wait for toileting. The PSW said that when the two staff go on break for 30 minutes was only the modified PSW on the floor at times. When asked if there was a routine to follow when they were short, the PSW said that it was an informal process on how to help one another in each area. The PSW said that they had brought their concern to the attention of the management staff.

During an interview this identified resident told Inspector #630 that they required a specific type of assistance from staff to clean their teeth. When asked if the staff assisted them to brush their teeth, the resident said that the staff helped them last night but not that morning.

During an interview another PSW said that they did provide care for the resident that morning and that they washed resident's mouth with a swab as they received care at night and so the staff do not need to do it in the morning. When asked if the resident had a toothbrush or toothpaste in their room the PSW said that they did not and that they did not complete the care for resident that morning and they were not aware of who provided that care.

During an interview another PSW said that they had started their shift after 0700 hours and had been called in for the shift. The PSW said that some of the morning care for residents was provided by night shift staff who stayed later. The PSW said they did not provide morning care to the resident.

During an interview another PSW said that they did not provide morning care for this resident as this was not one of their assigned residents. This PSW said they thought it might have been a different PSW.

The clinical record for this resident indicated that they required assistance from staff with dental care. The documentation in the Point of Care (POC) task "Oral Care provided as per RCP" for a specific time period indicated that oral care had not been provided on (3/30 days or 10 per cent) for one month and had only been provided once per day on 19/30 (63.3 per cent) of the days.

During an interview an agency RPN told Inspector #630 that they had been working in

the home intermittently over the past year as a RPN through an agency called Staff Relief. The agency RPN said that for some periods of time they would have no shifts and then another four shifts in one week. When asked which PSWs provided care to this identified resident that morning the agency RPN said that they did not know as there were three or four staff in that area. The agency RPN said that the home was short staffed that day and that at the start of the day shift they had staff from night shift stay longer and they thought they were short for a period of time. When asked what the process was when there was a shortage of staff for determining what care was to be done they said they thought it would depend on the residents' care plans but was not aware of a specific process.

During an interview the Director of Care (DOC) told Inspector #630 that staff would know the care a resident required related to oral care from the resident's care plan. The DOC said that when the staff started their shift they had a shift assignment and they had a routine and they generally had consistent residents. The DOC said that the PSWs were expected to be assisting with oral care once daily in the morning. The DOC said that the expectation was that the staff would be documenting the care they were provided in POC. When asked what the expectation was for staff regarding the care provided to this resident, the DOC said they should at least make sure the resident had everything they needed.

During a follow-up interview this identified resident told Inspector #630 that they needed assistance from staff to use the toilet and there were times when they have had to wait up to an hours for assistance with this care.

The clinical record for this resident showed they required specific types of assistance from staff with continence care. The Point of Care "Documentation Survey Report v2" for this resident showed the task "Toileting per RCP" was not documented as having been completed at specific times. The task "personal hygiene as per RCP" was not documented as having been completed at specific times. No bathing care documented as having been provided for a specific time period.

During a follow-up interview a PSW said that this resident needed specific assistance from staff with care. The PSW said that this resident was able to call for assistance when they needed help. This PSW said they were not aware of times when resident had not received the care required but there were times when the resident had to wait for care when there were staff shortages.

F) During an interview a RN told Inspector #630 that there had been times in the past three months when there have been PSW shifts that had not been filled and that happened almost daily for PSWs. When asked if there was a process to direct staff how to adjust their work routines when that happened, the RN said that it was typically up to the charge nurse to make the decision and sometimes that would be the night RN as the day RN shift did not start until 0700 hours. The RN said the charge nurse would direct the staff where to go and typically would not pull staff from an area that was already short. The RN said that the home had also been short registered nursing staff almost daily. The RN said that they felt that residents' care had been affected by the staff shortages such as residents not being put to bed for morning or afternoon rests, toileting not getting done promptly, the amount of time available for assisting residents with eating in the dining room, the registered staff not having as much time to spend with the residents to answer questions. The RN said that staff had been going without breaks and staying overtime to provide the care. The RN said that sometimes the Resident Care Coordinators (RCCs) have had to step in at times to assist with assessments and care.

During an interview a RCC told Inspector #630 that there had been staff shortages in the home. The RCC said this was related to staff vacations, leave of absences and resignations. The RCC said they had been recruiting PSW staff but there remained about four PSW lines that were empty. When asked if there had been residents in the home who have not received their preferred type of bathing care twice per week in the past three months, the RCC said they had back-up plans if running short and they would try to have extra staff come in the next day to make up baths. The RCC said the home had been struggling and they personally had assisted in the tub room on several occasions helping them the PSWs to do the care. RCC #139 said they thought there was a tracking form for deferred care but was not sure if it was being used. The RCC said that they believed that the work was being done but the documentation wad not getting completed at times when working short. The RCC said that they told the staff that if the care was not documented then it did not happen.

During an interview the DOC told Inspector #630 that the document titled "staffing levels August 2018" was the staffing plan for the home. The DOC said that based on the staffing plan it was expected that the ratio of residents to PSW staff in each area would be eight or ten to one plus additional PSW who worked the bath shifts. The DOC said that on the evening and night shifts the ratios went down. The DOC said that they were still trying to understand how the staff were divided and assigned to residents as the system that was in place was confusing. The DOC said that in order to support the

continuity of care they had staff assigned to specific areas on the PSW schedule. The DOC said that the home had been short PSW, RPN and RN staff during the summer months. The DOC said that the home had a back-up plan for situations when there was not the full complement of staff. The DOC said that they tried not to pull the bath shifts or the Behavioural Supports Ontario (BSO) shifts and that usually the decision were made by the registered staff prior to the DOC arriving in the morning. The DOC said that the registered staff would decide who was going to be pulled where with the suggestions from the Ward Clerk. The DOC said they thought that was being tracked on the staffing assignment sheet but they were not sure if this document was given to the staff working on the units. The DOC said that as they were fairly new to the home they were not very familiar with the "Staffing Plan/ Reassignment of Duties" policy and said that it was the expectation that this was followed. When asked if they used "Low Staffing Shift Routine Guidelines", the DOC said that the staff just automatically knew what needed to be done but as far as they knew this would be followed. When asked what was the process for management following-up after the back-up plan has been used on a shift to ensure that the residents' care and safety needs have been met, the DOC said that the management staff would do walk about on the floors but there was no documented record of this follow-up. The DOC said that they were not personally aware of any care or safety concerns for residents on the days when they were not fully staffed. The DOC said they did not think that he home's attendance management and performance program was actively in place in the home. The DOC said that the staff had not been able to complete the documentation of the care provided. The DOC said that they were not sure how many shifts, what days and in what areas the home was short PSW, RPN or RN hours. Inspector #630 requested that the DOC go through the schedules and tally that information in order to provide that information for the inspection.

During an interview a Ward Clerk told Inspector #630 that they were involved in scheduling staff in the home which included agency RPN staff. The Ward Clerk said they would attempt to fill vacant shifts with the home's own staff prior to contacting the agency to fill the shifts with agency staff. When asked what the plan or process was when working short staffed, the Ward Clerk said they would try to fill with overtime. When asked if there was a policy or process on what you do when there were empty shifts that they have not been able to replace, the Ward Clerk said they were not aware of any policy or program. The Ward Clerk said they tried their best and that the home had been really short staff but it was not by fault of calling people or offering overtime but that there were just not enough people or they had worn out the staff that were available.

During an interview the interim Executive Director (ED) told Inspector #630 that they had

just started in the role the day before on an interim basis. The Interim ED said that it was the expectation in the home that the staffing plan and the staffing back-up plan and policy would be followed. The interim ED said that the staffing plan was the document titled "staffing levels August 2018" was the current staffing plan and this was in place from May through to September 2018. The interim ED said that the process in the home to ensure the continuity of care was the master schedule and having lines scheduled for specific staff in specific areas of the home. When asked if prior to them starting in the home was there a method for tracking how many staff they have been short or where they were short, the interim ED said that the RCC would have conversations with the Ward Clerk but there was nothing documented. The interim ED said it was the expectation that the management in the home would know in what way on each shift the staffing plan was not being met. The interim ED said that the home has had to use the back-up plan in the past three months as they have been short shifts for PSWs, RPNs and RNs. The interim ED said that they were not aware of any care or safety concerns related to being short staffed. The interim ED said that staff had not been able to complete the required documentation of care on each shift and acknowledged that if care was not documented then it was difficult to verify if the care had been provided to the residents. The interim ED acknowledged that the home's staffing plan was evaluated in November 2017, and it was identified that an attendance management and performance program would be implemented in response to this evaluation. The interim ED said that they were not sure if this program had been fully implemented. The interim ED said that the home's job routines and duties were in the process of being reviewed and revised to ensure that the staff were organized in a way to ensure that the resident care needs were being met and that staff were clear which residents they were responsible for. The interim ED said that the home continued to make efforts to recruit more staff into vacant positions and continued to use agency RPNs to fill vacant shifts as needed. The interim ED said that the staffing plan policy indicated that all ADL's, baths, documentation, feedings, distribution of snacks for days and evenings was expected to be completed on each shift.

Based on these observations, interviews, record and policy reviews, the licensee has failed to ensure that the home's written staffing plan for the Nursing and Personal Supports program was complied with in order to meet the care and safety needs of the residents. (630) [s. 31. (3)]

Additional Required Actions:

CO # - 007 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 O.Reg 79/10, s. 52. Pain management

Specifically failed to comply with the following:

s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) During Stage one of the RQI Inspector #689 observed that an identified resident was showing signs of pain or discomfort.

During an interview a PSW said that they were familiar with this resident and this resident had chronic pain issues. The PSW said that the resident experienced pain when staff provided specific types of care and they would know this resident was in pain through non-verbal and verbal cues. The PSW said that some days were worse than others for the resident and there were interventions in place to help managed their pain. The PSW said that when the resident was showing signs of pain they would report this to the registered nursing staff.

The clinical record for this resident included the most recent Resident Assessment Instrument (RAI) assessment which indicated that the resident had mild pain daily. There were progress notes from the physician which identified changes in pain medication orders on specific dates. There were progress notes which stated that the

showing signs of pain. The electronic Medication Administration Record (eMAR) for specific time showed the resident had a documented pain rating four or greater on 25 days. There were no "CC Pain Assessment Tool" in PCC and no "Pain Management Flow Sheet" documented for the resident over a specific time period.

During an interview a RCC told Inspector #630 that they were familiar with this resident. The RCC said that this resident had known pain issues and had interventions in place to help manage the pain. The RCC said that based on the home's current pain assessment policy they would expect that a "CC Pain Assessment" was completed when the resident was complaining of pain or the pain was not controlled. Inspector #630 and the RCC reviewed the eMAR for the resident for a specific time period and the RCC acknowledged that there were times when the resident had a pain scale greater than four. The RCC said that the PCC documentation showed that the only "CC Pain Assessments" documented was one completed twelve days prior to the interview and one completed over six months ago. The RCC said that based on the policy it would also have been expected that a "Pain Management Flow Sheet" should have been completed when the resident's the pain was not relieved.

B) During an interview an identified resident told Inspector #630 that they had ongoing pain in specific locations. The resident said that they received pain medication to help manage their pain which included regularly scheduled medications and as needed medications. The resident said that sometimes staff would ask them if they had pain while at other times they needed to tell the staff about their pain and ask for the medication. The resident said that they felt there had been no real improvement in their pain level since their admission to the home. The resident said they were not sure if their pain had been assessed by staff in the home.

During an interview a PSW said that they were familiar with this resident and this resident was able to tell staff when they were experiencing pain. The PSW said they thought that this resident had pain related to a specific issue.

The clinical record for this resident included the most recent Resident Assessment Instrument (RAI) assessment which indicated that the resident had moderate pain daily. There were progress notes from the physician which identified changes in pain medication orders on specific dates. There were progress notes which stated that the resident was showing signs of pain. There were progress notes which showed that the resident had a reported pain level of greater than four on four different days. There was one "CC Pain Assessment Tool" in PCC for a specific date and no "Pain Management

Flow Sheet" documented for the resident over a specific time period.
During an interview a RCC told Inspector #630 that they were familiar with this identified resident. The RCC said that based on the "Pain Assessment" policy this resident would be expected to have a "CC Pain Assessment" completed any time that their pain was rated as greater than four. The RCC said that it was the expectation based on the policy that a "Pain Management Flow Sheet" was to be used when the pain medication did not relieve the pain. The RCC said they looked in the chart for this resident and could not located a completed "Pain Management Flow Sheet." The RCC said that this identified resident did have a change in their pain medication and it was the expectation that a "Pain Management Flow Sheet" would have been completed for seven days after that change.

C) During observations on specific dates Inspectors #435 and #630 observed that an identified resident was showing specific physical signs of potential pain.

During an interview a Registered Nurse (RN) told Inspector #630 that the process in the home for assessing a resident's pain involved speaking with them and using the pain scale and documenting this under vitals in PCC. The RN said that if a resident had a cognitive impairment they would go by the facial images. The RN said they were familiar with this identified resident and that this resident did have pain at times. The RN said that they would know this resident was experiencing pain through specific non-verbal cues. When asked how long the resident had been experiencing pain the RN said that it had been on and off since admission and there had maybe been more pain in the past year. When asked what type of pain assessment was done for this resident, RN said that there would be a paper pain assessment completed but they thought this did not apply to this resident and therefor the pain would be assessed using the "PAIN AD" in PCC.

During an interview a PSW told Inspector #630 that they were familiar with this resident. The PSW said that this resident experienced a lot of pain and would have specific non-verbal cues related to the pain. The PSW said that when a resident was showing signs of pain they reported it to the registered staff to have them check the resident and provide pain medications.

The clinical record for this resident included progress notes which indicated that pain was an ongoing concern. There was a progress note for a specific date which indicated that a family member reported concerns to a staff member about this resident's pain. For specific time periods were no documented "PAIN AD" assessments in PCC Weights, no

documented "Caressant Care Pain Assessment Tool" and no documented "Pain Management Flow Sheet" in the hard copy chart.

During an interview a Resident Care Coordinator (RCC) told Inspector #630 that a pain assessment was expected to be completed when a resident was complaining of pain, when pain was not well controlled or when there was a new pain medication ordered. The RCC said that there was a paper pain flow sheet as well as pain assessments in PCC using the numeric pain scale or "PAIN AD."

During a follow-up interview a RCC told Inspector #630 that they looked in the chart for this resident and could not located a documented "Pain Management Flow Sheet." Inspector #630 and the RCC reviewed the assessment section in PCC and the RCC acknowledged that there was no pain assessment documented for this resident. The RCC said it was the expectation that staff would have completed "CC Pain Assessment" and the "Pain Management Flow Sheet" for this resident as they were exhibiting behaviours that may herald the onset of pain and the pain was remaining regardless of interventions. The RCC said that this resident was unable to use the numeric pain scale and staff would be expected to use the "PAIN AD" to assess and document the resident's pain. The RCC said that staff in the home were expected to be documenting the pain levels in PCC vital signs and acknowledged that the use of these tools were not included in the current pain assessment policy. The RCC said that based on the current policy it was the expectation that staff would be completing the completed "CC Pain Assessment" and the "Pain Management Flow Sheet" as directed in the policy. The RCC said that the staff in the home had not received education on this specific policy and they had an education session planned for later this month on documentation of pain monitoring and assessments.

Based on these observations, interviews, record reviews and policy review the licensee has failed to ensure that the home's "Pain Assessment" policy was complied with in order to ensure that when these identified residents' pain were not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (630) [s. 52. (2)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
9. Every resident has the right to have his or her participation in decision-making respected. 2007, c. 8, s. 3 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident's right to have his or her participation in decision-making was fully respected and promoted.

During an interview, when asked if they felt the staff in the home treated them with respect and dignity, an identified resident told Inspector #630 that they felt that sometimes the staff did not listen to them. This resident stated that it upset them that the staff would talk to their family member about care decisions instead of directly to them.

During an interview a Registered Nurse (RN) told Inspector #630 that they would know

whether a resident was their own decision maker by looking in the profile section in PointClickCare (PCC). The RN said they thought that was set up at admission by the administration. When asked how they would know if a resident was involved in making decisions about their care, the RN said that they could involve the resident if they were cognitively well and it would depend on the resident.

The clinical and administrative record for this resident did not include clear documentation regarding who was making care decisions.

During an interview a Resident Care Coordinator (RCC) told Inspector #630 that staff in the home would know whether a resident was the one to make their decisions or a Substitute Decision Maker (SDM) by their CPS (Cognitive Performance Scale (CPS) score and their cognitive capabilities and that there was a questionnaire on admission to ask those questions. The RCC said that they thought there was a process at admission for determining the POA or SDM and this was included in their PCC profile. The RCC said that they thought it was Administrative Assistant (AA) who set up the profile in PCC. The RCC said that staff would know who to contact about decisions through the PCC profile. The RCC acknowledged that this resident had identified a concern about who was making care decisions during a care conference. When asked if this was identified anywhere in the resident's plan of care or PCC profile, the RCC said that they did not know if anything was done.

During an interview the Administrative Assistant (AA) said that when they met with a resident or family at the time of admission they would try to obtain a copy of the legal documentation for POA for property and personal care. The AA said that they would be notified by the Assistant Director of Care (ADOC) or RCC whether a resident was cognitively well enough to sign their own papers. The AA said that they were not responsible for setting up the profile in PCC when a resident was admitted as that is input by whoever input the information at admission. The AA said that sometimes they would update the profile if it was incomplete. The AA said they had met with this resident at admission with their family member and that the resident signed their own papers. The AA said they did not set-up the profile in PCC for resident and that they did not have POA papers on file for this resident.

During an interview the Director of Care (DOC) told Inspector #630 that staff would know whether a resident was making decisions for themselves or whether there was someone else making decisions on their behalf through the documentation and plan of care. The DOC said that staff would know through speaking with the resident as to whether the

resident was able to answer for themselves. The DOC said that they thought it was the RAI Coordinators who were responsible for setting up the profiles in PCC. The DOC reviewed the PCC profile for this resident and said that it identified a family member as the POA and that resident was not listed in this profile as a contact. The DOC said that for staff to know that the resident was making their own decisions it should be identified in the chart.

The licensee has failed to ensure that this identified resident's right to have their participation in decision making was fully respected and promoted. (630) [s. 3. (1) 9.]

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

A) On a specific date Inspector #522 observed an unattended medication cart with the electronic Medication Administration Record (eMAR) screen open with resident information visible on the screen. One resident was seated in a chair and one resident was seated in a wheelchair across from the cart.

Inspector waited for the Registered Nurse (RN) to return to the medication cart. The RN confirmed that they had left the medication cart unattended with the eMAR screen open with resident information visible. The RN stated the eMAR screen should have been locked when they left the medication cart unattended.

B) On another date Inspector #522 observed an unattended medication cart with the electronic Medication Administration Record (eMAR) screen open with resident information visible on the screen in the hallway. Approximately two minutes later Inspector observed the RPN leave a resident's room at the other end of the hall.

During an interview, the RPN confirmed that they had left the medication cart unattended with the eMAR screen open with resident information visible. When Inspector #522 inquired if the RPN normally locked the eMAR screen when the medication cart was unattended, the RPN stated they were not gone long, locked the eMAR screen and walked away.

During an interview the Director of Care (DOC) stated the home's expectation was that when a medication cart was left unattended the eMAR screen was closed and resident

information was not visible.

The licensee has failed to ensure that the following rights of residents were fully respected and promoted: To have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act. (522) [s. 3. (1) 11. iv.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the following rights of residents are fully respected and promoted: every resident has the right to have his or her participation in decision-making respected and every resident has the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
1. All doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be,
i. kept closed and locked,
ii.equipped with a door access control system that is kept on at all times, and
iii.equipped with an audible door alarm that allows calls to be cancelled only at the point of activation and,
A. is connected to the resident-staff communication and response system, or
B. is connected to an audio visual enunciator that is connected to the nurses' station nearest to the door and has a manual reset switch at each door.
O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to, were kept closed and locked.

During the Resident Quality Inspection (RQI) initial tour a stairwell door was open and unlocked. The stairwell door was easily opened and an alarm sounded in the hallway. Several staff and a visitor looked at the alarm panel on the wall and walked away. A Personal Support Worker (PSW) approached the stairwell door and coded the key access and the alarm stopped. The PSW was then asked to push on the exit door to the stairwell and it opened easily without having to use the code. The PSW stated that the alarm sounded throughout the entire floor and the location of the alarm would light up at the main panel at the nursing station. The PSW was asked to notify the Executive Director.

The Executive Director (ED) arrived and stated the stairwell door should be closed and locked at all times. The ED tested the door and it easily opened and alarmed without coding the key pad access to exit. The same resident attempted to open the door again with the ED present. The ED acknowledged that even though the door was closed and latched it still opened and alarmed without key pad access.

A PSW arrived at the exit door to maintain closure s and verified that the door should be closed and locked at all times. The PSW stated that the red light on the key code indicated the door was locked. The PSW then pushed the door open and verified that the door opened and the alarm sounded without pushing in the key code.

During an interview the Environmental Services Supervisor (ESS) stated the magnet had popped out of the door preventing the exit door from locking.

The licensee failed to ensure that the door leading to a stairway and the outside of the home was kept closed and locked. (522) [s. 9. (1) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to stairways and the outside of the home other than doors leading to secure outside areas that preclude exit by a resident, including balconies and terraces, or doors that residents do not have access to must be kept closed and locked, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1.During Stage one of the RQI, Inspectors #563, #689 and #721 noted disrepair in resident rooms and bathrooms. The Environmental Service Supervisor (ESS) toured the home on a specific date, including resident rooms and common areas, with Inspector #563 and Inspector #721 and the ESS verified that there were multiple areas of disrepair in common areas and resident rooms.

The Caressant Care Nursing & Retirement Homes Ltd. "Preventative Maintenance Program for Resident's Rooms/Common Areas" policy last reviewed August, 2017, stated:
- "On a quarterly basis the Administrator and/or maintenance staff will inspect every room. An items found faulty will be recorded for repair using the Action Plan form. Administrator and maintenance staff will prioritize the Action Plan and review on an on-going basis. Please note that items found faulty between preventative maintenance checks will still be requisitioned for repair in the usual manner".

Based on observations, staff interviews and record review of policies and procedures related to the preventative maintenance for resident rooms and common areas, the licensee failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair. (522) [s. 15. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Section 2(1) of the Ontario Regulation 79/10 defines neglect as "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, including inaction or a pattern of inaction that jeopardizes the health or safety of one or more residents."

On a specific date a former Director of Care (DOC) emailed the Ministry of Health and Long-Term Care (MOHLTC) regarding a written letter of complaint. This email had an attached written letter of complaint to the former DOC from a family member for an identified resident which was dated 14 days prior to the email. This letter had a written note on the top which indicated it was received seven days prior to the email.

The letter of complaint dated included concerns regarding the care provided to the identified resident by specific staff on a specific date.

The "Complaint Form" dated stated that an identified staff member had received counselling regarding the care provided on that date. This form stated that they had spoken with the family member who had written the complaint and "discussed concerns" with no further documentation of that discussion. This complaint form also indicated under actions taken that “the agency nurse” that was working on a specific date would not “be used by us again" with no further details regarding this action or the information that lead to that action.

A letter dated from a former ED to the family member for this resident stated "I have received and reviewed the complaint that you made." The letter also stated "an investigation was conducted."

During an interview a Resident Care Coordinator (RCC) said they were working in the home at the time of this complaint letter but did not recall any details related to an allegation or investigation into staff to resident abuse or neglect for this resident .

The home's policy, that was in effect in January 2018, titled "Abuse & Neglect – Staff to Resident, Family to Resident, Resident to Resident, Resident and/or Family to Staff" with last review date February, 2017, stated:
- "At the time of hiring, the new employee will receive the abuse educational package and will sign the Acknowledgement Sheet indicating they have read and understood the policies."
- "The DON and/or Administrator will interview all parties and maintain a written record using the Abuse – Resident Incident Report (Appendix A)."

During interviews the interim ED told Inspector #630 that the process in the home for responding to written complaints was to document the complaint, investigate, fully responded to the complaint and report to authorities immediately. The interim ED said that the expectation was that allegations of staff to resident neglect or abuse would be reported to the MOHLTC through the Critical Incident System (CIS). The interim ED said that based on the contents of the written complaint from the family of this resident it met the definition of an allegation of improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. The interim ED said that they were not working in the home at the time of this complaint letter and that the DOC who was involved in responding to this letter was no longer working in the home. The interim ED said that based on the documentation they had available to them there was no CIS report submitted to the MOHLTC regarding this allegation of neglect and they were not sure how or when the MOHLTC was notified. The interim ED said they could not locate any further documentation regarding this investigation apart from the written letter of complaint, the "Complaint- form" and the response letter from the former ED to the family. The interim ED said that they were unable to determine the full name of the agency staff who had been involved and did not have documented evidence that this agency staff had received education on the home policy on the prevention of abuse and neglect prior to working in the home. The interim ED said that based on the documentation available to them they were unable to determine if any staff had been interviewed as part of this investigation. The interim ED provided a copy of the home's prevention of abuse and neglect written policy and said it was the expectation that this policy would be complied with in regards to the documentation of investigations and the education of staff as identified in the policy prior to working in the home. The interim ED said that based on the documentation it was difficult to determine the conclusions of the

whether or not resident had been neglect by the staff in the home.

Based on these interviews and record review the licensee has failed to ensure that the home's written policy to promote zero tolerance of abuse and neglect of residents was complied with. (630) [s. 20. (1)]

Additional Required Actions:

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

WN #13: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that when a person who had reasonable grounds to suspect that improper or incompetent treatment or care of a resident had occurred that resulted in harm or a risk of harm to the resident, they immediately reported the suspicion

and the information upon which it was based to the Director.

A) On a specific date a former DOC emailed the Ministry of Health and Long-Term Care (MOHLTC) regarding a written letter of complaint. This email had an attached written letter of complaint to the former DOC from a family member for an identified resident which was dated 14 days prior to the email. This letter had a written note on the top which indicated it was received seven days prior to the email.

The letter of complaint included concerns regarding the care provided to the identified resident by specific staff on a specific date.

During an interview the interim ED told Inspector #630 that the process in the home for responding to written complaints was to document the complaint, investigate, fully responded to the complaint and report to authorities immediately. The interim ED said that the expectation was that allegations of staff to resident neglect or abuse would be reported to the MOHLTC through the Critical Incident System (CIS). The interim ED said that based on the contents of the written complaint from the family of this resident it met the definition of an allegation of improper or incompetent treatment or care of a resident had occurred that resulted in harm or a risk of harm to the resident. The interim ED said that they were not working in the home at the time of this complaint letter and that the DOC who was involved in responding to this letter was no longer working in the home. The interim ED said that based on the documentation they had available to them there was no CIS report submitted to the MOHLTC regarding this allegation of neglect and they were not sure how or when the MOHLTC was notified.

Based on these interviews and record review a former ED and a former DOC failed to immediately reported the suspicion and the information upon which it was based to the Director, when they had reasonable grounds to suspect that improper or incompetent treatment or care of a resident had occurred that resulted in harm or a risk of harm to the resident (630).

B) A Critical Incident System (CIS) report was submitted to the MOHLTC by the home related to an incident of alleged staff to resident verbal abuse on a specific date.

A review of the home's investigative notes indicated that a Personal Support Worker (PSW) had verbally reported concerns of another PSW verbally abusing an identified resident during the resident's bath to a Resident Care Coordinator (RCC) on a specific date. The notes stated the PSW was asked to put their concerns in writing and this was

submitted to RCC one day later.

During an interview the RCC acknowledged that a PSW had reported concerns of staff to resident verbal abuse to them and that they requested the PSW to submit their concerns in writing. The RCC stated that the previous Executive Director or Director of Care would have been responsible to report the alleged abuse to the Director and submit the CIS report.

During an interview the interim Executive Director (ED) stated that the allegations of staff to resident verbal abuse should have been immediately reported to the Director.

The licensee has failed to ensure that a person who had reasonable grounds to suspect that abuse of a resident by anyone had occurred or may occur, immediately reported the suspicion and the information upon which it was based to the Director. (522) [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a person who has reasonable grounds to suspect that any of the following has occurred or may occur immediately reports 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, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

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

O. Reg. 79/10, s. 30 (1) 1. states that 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.

Specifically the home did not comply with the "Nursing Department" policy titled "Documentation in Resident Health Record" with review date April 2018. This policy included the following procedure:
- "All documentation in the health record will be: complete and accurate"

During an interview a family member for an identified resident reported concerns that a specific device owned by the resident had gone missing and had been damaged multiple times in the home. This family member said they wished they had been notified sooner as they would have come into the home to help look for the item. This family member said they did report their concern with the hearing aid to the staff.

During an interview a PSW told Inspector #630 that they were familiar with this resident.

The PSW said they would look in the plan of care to determine the care that a resident required related to this device and they would document the care they provided on the computer in PointClickCare (PCC) Point of Care (POC). The PSW said they had received education in the home on how to complete that documentation. The PSW said that this resident required this device and at the time of the interview a device was missing.

On a specific date Inspector #630 observed a registered staff member go into this resident's room and they said to the resident that they were applying one device but they were unable to apply the other device as it was missing.

During an interview a RN said that they were familiar with this resident. The RN said that this resident had a missing device. The RN said that the care related to device was listed for registered staff in the electronic Medication Administration Record (eMAR) directing staff to provide care related to the device in the morning and the evening. The RN said that it was hard to keep track of whether the device had been missing before.

The clinical record for this resident included progress notes for specific dates indicating that the device was missing. The Point of Care (POC) "response history" report for the resident for specific dates included a task related to this device. This care documented in this task was not accurate. The eMAR for this resident for a specific time frame included an order related to this device. The care documented in this eMAR for this device was not accurate.

During an interview a Resident Care Coordinator (RCC) told Inspector #630 that care related to this type of device was documented in POC and eMAR for most residents. The RCC said that if there was a missing device they would expect that to be captured in the documentation as a "not applicable" and then a note or in the eMAR coded as a "nine" and then a progress note to indicate one was missing. The RCC said they were familiar with this resident and thought that there was a missing device. Inspector #630 and the RCC reviewed the POC and eMAR documentation for this resident and the RCC acknowledged that the documentation was not accurately reflecting the care related to hearing aids.

During an interview the interim ED said it was the expectation in the home that the "Documentation in Resident Health Record" policy with effective date April 2018, was followed by the staff in the home. The interim ED said that this policy was part of the Nursing and Personal Support Services program in the home. The interim ED

acknowledged that it was difficult to determine when the resident's device was missing or not provided as per the plan of care when the documentation of this care was not accurate.

The licensee has failed to ensure that the actions taken with respect to this identified resident's device as part of the Nursing and Personal Support Services program were documented. (630) [s. 30. (2)]

Additional Required Actions:

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

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was bathed, at a minimum, twice a week by the method of his or her choice and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

The Ministry of Health and Long Term Care (MOHLTC) received a complaint from an anonymous source who reported a concern related to bathing care for an identified resident.

During an interview this resident told Inspector #630 that there was a specific period of time after they moved into the home when did not receive a bath or shower. This resident said they did have a concern about the bathing care that they were receiving in the home and that it seemed that there were not enough staff available to provide the care needed. This resident said they had a specific preference related to the type of bathing care they received.

During an interview a PSW said they were familiar with this resident. This PSW said that it was expected that residents would be provided with two baths or showers per week. The PSW said they document in Point of Care (POC) when a resident has been given a bath or a shower and whether a resident had refused that care. The PSW said that this resident preferred to have a specific type of bathing care and required assistance from staff with bathing care.

The clinical record for this resident showed that the first documented shower that resident received in the home was 14 days after admission, the first documented bed bath that the resident received in the home was 17 days after admission and the first documented tub bath that the resident received was 22 days after admission. The plan of care for this resident identified they preferred a specific type of bathing care. The Point of Care (POC) report for specific time periods showed that this resident had not received their preferred type of bathing care five out of 22 of their designated bathing days.

During an interview a RCC told Inspector #630 that it was the expectation in the home that residents would receive two baths or showers per week of their preferred type and their preferred time in terms of days or evenings. The RCC acknowledged that the home had been working without the full complement of PSW staff over the past three months and that they had been trying to ensure the residents had been receiving their required bathing care during that time. The RCC and Inspector #630 reviewed the POC documentation for this resident and the RCC acknowledged that there was a fourteen day period after admission where this resident did not receive their preferred bathing care as per the documentation. The RCC said that it is the expectation in the home that documentation would be completed to reflect the care provided and that they told staff that if it was not documented then it was not completed.

The licensee has failed to ensure that this identified resident was bathed, at a minimum, twice a week by the method of their choice. (630) [s. 33. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to 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, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home received oral care to maintain the integrity of the oral tissue that included mouth care in the morning and evening.

A) During Stage one of the Resident Quality Inspection (RQI), an identified resident was coded as having oral/dental problems from the most recent full Resident Assessment Instrument (RAI) assessment.

Review of the most recent RAI annual assessment indicated that the resident had some or all natural teeth lost and broken, loose, or carious teeth.

During an interview a Personal Support Worker (PSW) stated that the expectation was that staff were to provide oral care assistance to residents twice daily and document the oral care in Point of Care (POC).

A review of the resident's care plan showed that staff were to brush the resident's teeth every morning and in the evening.

The "Personal Care Hygiene" task in POC documented "Personal Care Hygiene as per RCP" by Personal Support Workers (PSWs) for a 30 day look back period for a specific time period. For 15 of 30 days, (50 per cent) oral care was provided once a day, and for 11 of 30 days (37 per cent) no mouth care was provided to the resident.

During an interview the Director of Care (DOC) reviewed the POC task documentation related to personal care hygiene for this resident and verified that the expectation was that oral care should be provided and documented twice daily.

The licensee has failed to ensure that the resident received oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening. (689)

B) During an interview a PSW said that they would know what care a resident required with dental care by the plan of care and asking the resident. The PSW said that another identified resident was able to clean their own teeth and the staff assisted specific tasks.

During an interview this identified resident told Inspector #630 that they required staff assistance with brushing their teeth. When asked if the staff assisted them to brush their teeth, the resident said that the staff helped them the night before but not in the morning.

During an interview another PSW said that they did provide care for the resident that morning and that they washed resident's mouth with a swab as they received care at night and so the staff do not need to do it in the morning. When asked if the resident had a toothbrush or toothpaste in their room the PSW said that they did not and that they did not complete the care for resident that morning and they were not aware of who provided that care.

During an interview another PSW said that they had started their shift after 0700 hours and had been called in for the shift. The PSW said that some of the morning care for residents was provided by night shift staff who stayed later. The PSW said they did not provide morning care to the resident.

During an interview another PSW said that they did not provide morning care for this resident as this was not one of their assigned residents. This PSW said they thought it might have been a different PSW.

The clinical record for this resident indicated that they required assistance from staff with dental care. The documentation in the Point of Care (POC) task "Oral Care provided as per RCP" for a specific time period indicated that oral care had not been provided on (3/30 days or 10 per cent) for one month and had only been provided once per day on 19/30 (63.3 per cent) of the days.

During an interview the Director of Care (DOC) told Inspector #630 that staff would know the care a resident required related to oral care from the resident's care plan. The DOC said that when the staff started their shift they had a shift assignment and they had a routine and they generally had consistent residents. The DOC said that the PSWs were expected to be assisting with oral care once daily in the morning. The DOC said that the expectation was that the staff would be documenting the care they were provided in POC. When asked what the expectation was for staff regarding the care provided to this resident, the DOC said they should at least make sure the resident had everything they needed.

Based on these interviews and record review this identified resident did not receive oral care that included mouth care in the morning and evening, on a consistent basis during a specific time period. (630) [s. 34. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident receives oral care to maintain the integrity of the oral tissue, including mouth care in the morning and evening, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 40. Every licensee of a long-term care home shall ensure that each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear. O. Reg. 79/10, s. 40.

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident was dressed appropriately and in appropriate clean footwear.

During Stage one of the Resident Quality Inspection (RQI) Inspector #630 observed that an identified resident was dressed in clothing and footwear that did not fit properly. This resident was also observed to be was wearing mismatched footwear.

During an interview a Personal Support Worker (PSW) said that this resident required the assistance of staff with dressing and that the resident had a lot of clothing that did not fit properly. When asked if that had been brought forward to the family, the PSW said they were not sure. The PSW said that the resident had a specific item of footwear that had been missing and in the meantime had only been wearing socks. The PSW said the staff had tried to look for the missing item.

During an interview a Registered Practical Nurse (RPN) said that this resident was totally dependent on staff for assistance with dressing. The RPN said that this resident did have shoes and liked to remove them and was more comfortable without shoes. The RPN said that no one had reported missing footwear item to them. When asked if there had been a change in the resident's clothing needs, the RPN said that they had observed that resident's clothing were not fitting properly. When asked if staff had contacted the family about the clothing, the RPN said that they were not sure and they personally had not contacted the family.

During an interview another RPN said that if they noticed a resident was wearing clothing that did not fit then they would notify the family to bring in more clothing and this would be documented in PointClickCare (PCC). The RPN said that they had conversations in the past with resident's family regarding clothing needs but was not sure if there had been any recent requests as this resident had a change in clothing needs. This RPN

said they could not see anything documented in PCC regarding contact with the family about clothing. The RPN said that the resident usually wore a specific type of footwear and was not aware of any concerns with the resident's footwear.

During an interview the Director of Care (DOC) said that staff were expected to dress residents with socks and shoes and preferably the shoes would be matching. The DOC said that sometimes residents did not have the clothing that they required and then staff would contact the family. The DOC said that contact with the family regarding requests for clothing would be documented in the progress notes. When asked if there was any documentation in PCC regarding contacting the family about the resident's clothing, the DOC said that the last documentation was May 2017 and there was nothing more recently documented. The DOC said that the expectation in the home was if a resident's clothing item was missing the staff would look for the item and document.

Based on these observations and interviews the licensee has failed to ensure that this identified resident was dressed in appropriate clothing and was wearing appropriate clean footwear. (630) [s. 40.]

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 each resident of the home is assisted with getting dressed as required, and is dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing and in appropriate clean footwear, to be implemented voluntarily.

WN #18: 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,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1.During an interview the RAI-Coordinator told Inspector #630 that an identified resident required a specific type of continence care.

During an interview this identified resident said that they had experienced a change in their continence care needs.

During an interview a Personal Support Worker (PSW) told Inspector #630 that they would look in the plan of care to know what care a resident required related to continence care in addition to knowing the residents. This staff member said they were familiar with this resident and this resident had a recent change in their care needs and had become incontinent.

During an interview a Registered Practical Nurse (RPN) told Inspector #630 that staff completed continence assessments on admission and on a quarterly basis and they could also do an assessment in-between the quarterly if needed for a resident. The RPN said that if there was a change in continence status the RAI Co-ordinators would change the plan of care but the registered staff could also update the plan of care if there was an urgent issue. The RPN said they were familiar with this resident and there had been a change in the continence care needs. The RPN acknowledged that at the time of the interview this resident's plan of care did not reflect the resident's care needs.

The clinical record for this identified resident did not include a "Continence Care Assessment" which reflected the change in continence care. There were multiple progress notes which indicated there had been a change in the resident continence status. The plan of care had not been updated to reflect the change in continence status.

During an interview a Resident Care Co-ordinator (RCC) told Inspector #630 that they were the lead for the Continence Care Program in the home. The RCC said that it was the expectation in the home that a resident's continence care would be reassessed by staff when there was a change in condition and typically that was done by the RAI office through the quarterly assessment. The RCC said that they thought that a continence care assessment was not necessarily done for this type of change as it would be a nursing assessment and a physician assessment. The RCC said that they had not been made aware of the specific changes in this resident's care needs. The RCC said that it was the expectation in the home that staff would notify them of this change and that the

plan of care would be updated to reflect the continence care needs of the resident.

During a follow-up interview the RCC said that the home's current Bladder and Bowel Management Program policy directed staff that they were to do a continence status assessment any time there was a change of status which meant any time there was a change in continence needs. The RCC said that the current policy did not direct staff to update the plan of care when there was a change in continence care needs but it was the expectation in the home that this would be completed to ensure the PSWs would know what care the residents required.

Based on these interviews and record review the continence care set out in the plan of care for this identified resident was not based on an assessment of the resident and the

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 each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (2) The licensee shall ensure that a documented record is kept in the home that includes,
(a) the nature of each verbal or written complaint; O. Reg. 79/10, s. 101 (2).
(b) the date the complaint was received; O. Reg. 79/10, s. 101 (2).
(c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; O. Reg. 79/10, s. 101 (2).
(d) the final resolution, if any; O. Reg. 79/10, s. 101 (2).
(e) every date on which any response was provided to the complainant and a description of the response; and O. Reg. 79/10, s. 101 (2).
(f) any response made in turn by the complainant. O. Reg. 79/10, s. 101 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that a documented record was kept in the home that included, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant.

A family member for an identified resident reported concerns to Inspector #630 that a specific device that the resident owned had gone missing or damaged multiple times in the home. This family member said they did report their concern with the hearing aid to the staff.

During an interview a RN said that they were familiar with this resident. When asked what was the process in the home if it was identified either through observations or a report from a family member or resident that something was missing, the RN said they would let the family know and look thoroughly in the room and in the laundry. The RN said they would also put a message in the communication book and on the home page and if it did not show up in timely fashion we get back to the family about the missing aid. The clinical record for this identified resident included progress notes which indicated that the resident's specific device was missing and the family had discussed this with staff.

During an interview a RCC said that when there was a reported missing item in the home there was a receipt book that was to be used to document the missing item. The RCC said that depending on the situation this could be considered a complaint depending on the family member and the article that was missing. When asked if it was the expectation in the home whether the complaint process would be followed if there was a missing item or if there was a different policy, the RCC said they checked and there was not a separate policy regarding missing items and that they would ask other members of the management team about that as they were not sure. The RCC said that this resident did have a missing device but they had not personally been informed of any family concerns with the missing item. The RCC said they could not locate documentation to show that a receipt document had been created for this resident's missing device.

The home's policy titled "Complaints - Process" with reviewed date June 2018 included the following definition "complaint - a verbal or written expression of dissatisfaction or concern by a resident, family member or other person(s) with the care or services provided by the home and requiring acknowledgement and action." This policy stated that "all verbal or written complaints concerning the care of a resident or the operations of the home will be documented, investigated and formally responded to." This policy stated "The complaint form will be completed and submitted to the Corporate Office."

During an interview the interim ED told Inspector #630 that the home currently did not have a policy or procedure on responding to reported missing resident items such as the type of device this resident was missing. The Interim ED said that from what they understood when an item was reported missing the nursing and PSW staff would look for the item. The interim ED said that based on the definition of complaint in the home's policy the reporting of a missing item from a resident or a family member would meet the definition of a complaint. The interim ED and Inspector #630 reviewed the progress notes for this resident regarding the missing device and the interim ED said that in their opinion this was considered to be a complaint from the family. The interim ED said they looked for a documented complaint form for this complaint and could not locate that there had been documentation regarding this complaint. The interim ED said it was the expectation in the home that complaints would be documented as per the policy and using the complaint form.

The licensee has failed to ensure that a documented record was kept in the home regarding the verbal complaint regarding a resident's missing device that included, (a) the nature of the verbal complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for

actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant. (630) [s. 101. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a documented record is kept in the home that includes, (a) the nature of each verbal or written complaint; (b) the date the complaint was received; (c) the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required; (d) the final resolution, if any; (e) every date on which any response was provided to the complainant and a description of the response; and (f) any response made in turn by the complainant, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) At a specific time Inspector #522 observed an unattended and unlocked medication cart. One resident was seated in a chair and one resident was seated in a wheelchair across from the cart.

Inspector #522 waited for the Registered Nurse (RN) to return to the medication cart. The RN confirmed that they had left the medication cart unattended and unlocked. The RN stated the medication cart should have been locked when they left the medication cart unattended.

B) At a specific time Inspector #522 observed another unattended and unlocked medication cart in the hallway. Approximately two minutes later, Inspector observed a RPN leave a resident's room at the other end of the hall.

During an interview the RPN confirmed that they had left the medication cart unattended and unlocked. When Inspector #522 inquired if the RPN normally locked the medication cart when the medication cart was unattended, the RPN stated they were not gone long, locked the medication cart and walked away.

During an interview the Director of Care (DOC) stated the home's expectation was that the medication cart was locked when the cart was left unattended.

The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secure and locked. (522) [s. 129. (1) (a) (ii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that drugs are stored in an area or a medication cart that was secure and locked, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control (IPAC) program.

A) The licensee has failed to ensure that staff participated in the implementation of the infection prevention and control program.

Observations of resident rooms on specific dates found numerous unlabelled resident personal care items in identified residents' shared bathrooms. These items included urinals, hairbrushes, a commode pan, cleansers, creams, tooth brushes, toothpaste, peri-wash, lipstick and a bar of soap.

Review of the home's quality "CC Resident Care Audit" noted the following indicator was to be checked: #26. All personal "care items are clearly labelled with resident's name – toothbrush, denture cup, comb, hairbrush."

During an interview a Personal Support Worker (PSW) told Inspector #524 and #721 that all personal care items for residents were to be labelled and kept in the resident's specific caddie. The PSW said that if they saw a resident personal care item unlabelled they would get a marker and label the item.

During an interview a Resident Care Coordinator (RCC) said it was everyone's responsibility to ensure that residents' personal care items were labelled with the resident's name when stored in shared bathrooms.

During an interview interim Executive Director (ED) acknowledged that residents' personal care items stored in resident shared bathrooms should be labelled as part of the infection prevention and control program. (524)

B) During the Resident Quality Inspection (RQI) initial tour, the Whirlpool Room on B side on Level one was observed. There was an unlabelled container on the shelving unit located between two shower stalls. There were unlabelled personal care products

observed which included deodorant, creams, a bar of soap, nail clippers, disposable razors, hair accessories, hair brushes, combs, mouth wash.

The Environmental Service Supervisor (ESS) entered the whirlpool room and observed that there was clean linen on two shelving units where there was dried brown green liquid and an accumulation of dust present. Inspector #563 showed the closet area with personal care products and nail clippers on the floor and the ESS verified that the floors were unclean and that the commode pail with green sludge contained unlabelled soap containers and nail clippers.

The Director of Care (DOC) came into closet area as well and verified that several personal care items were not labelled or stored in a clean and appropriate manner. The DOC was shown the labelled and unlabelled products in the unmarked containers on the shelving units and verified that the nail clippers were unclean, unlabelled and used. Inspector #563 showed the DOC a bar of soap used, unlabelled and not packaged and the DOC acknowledged that the soap could have been used on multiple residents since it was not labelled. The DOC stated that all personal care items used by a resident were to be labelled, and that each resident had a caddy for their own personal items to be kept in the resident's room until their bath or shower. The DOC also stated that the accumulation of unclean and unlabelled items in the unlabelled containers should not be accessible for staff use. The DOC verified that staff did not participate in the implementation of the IPAC program.

The licensee has failed to ensure that staff labelled and properly stored personal care items in a clean manner in the Whirlpool Room for each resident. (563) [s. 229. (4)]

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 staff participated in the implementation of the infection prevention and control program, to be implemented voluntarily.

WN #22: 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).

Findings/Faits saillants :

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

A Critical Incident System (CIS) report was submitted to the MOHLTC by the home related to an incident of alleged staff to resident abuse that occurred on a specific date.

A review of the home’s investigative notes indicated that a Personal Support Worker (PSW) had verbally reported concerns of another PSW abusing a resident during their care to a Resident Care Coordinator (RCC) on a specific date. The notes stated the PSW was asked to put their concerns in writing and this was submitted to the RCC a day later.

During an interview the RCC acknowledged that a PSW had reported concerns of staff to resident abuse to them on a specific date and that they requested the PSW to submit their concerns in writing. The RCC stated that when staff brought forth a concern verbally they were asked to submit their concern in writing and once the written concern was received then an investigation would be initiated.

During an interview the interim Executive Director (ED) stated that an investigation should have been initiated immediately when the PSW reported concerns of staff to resident abuse.

The licensee has failed to ensure that every alleged, suspected or witnessed incident of abuse of a resident by anyone that that was reported, was immediately investigated. (522) [s. 23. (1) (a)]

WN #23: 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 :

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

During an interview the interim Executive Director (ED) was asked to provide the written record of the last annual evaluation of the home's policy to promote zero tolerance of abuse and neglect. The interim ED said they thought that an annual evaluation had been completed as the "Program Evaluation 2017" summary showed that there had been one completed April 18, 2017. The interim ED said that they could not locate the written record of the evaluation and had contacted the Caressant Care Corporate office and they could also not locate a copy of the evaluation. The interim ED said that the ED and the DOC who were working in the home at the time of the evaluation were no longer working in the home and no one that they spoke with on the current management team knew the whereabouts of the evaluation record. The interim ED said that based on their understanding the evaluation for 2018 had not yet been completed for the calendar year.

Based on the interview with the interim ED and the documentation available at the time of the inspection there was insufficient evidence to show that there was a written record of the 2017 annual evaluation of the policy to promote zero tolerance of abuse and neglect of residents. (630) [s. 99. (e)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 104. Licensees who report investigations under s. 23 (2) of Act

Specifically failed to comply with the following:

s. 104. (1) In making a report to the Director under subsection 23 (2) of the Act, the licensee shall include the following material in writing with respect to the alleged, suspected or witnessed incident of abuse of a resident by anyone or neglect of a resident by the licensee or staff that led to the report:
2. A description of the individuals involved in the incident, including,
i. names of all residents involved in the incident,
ii. names of any staff members or other persons who were present at or discovered the incident, and
iii. names of staff members who responded or are responding to the incident. O. Reg. 79/10, s. 104 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident.

A Critical Incident System (CIS) report was submitted to the MOHLTC on a specific date related to an incident of alleged abuse.

A review of the CIS noted that Personal Support Worker (PSW) students had reported to the Director of Care (DOC) that a staff member had been "inappropriate" in their care for residents, rough and very vocal towards an identified resident and fed another resident quickly, when it appeared they did not want to eat.

The CIS report did not include the name of the staff member involved.

In an interview the interim Executive Director (ED) stated that the name of the staff member accused of inappropriate care should have been included in the CIS report.

The licensee has failed to ensure that the report to the Director included the following description of the individuals involved in the incident: (ii) names of any staff members or other persons who were present at or discovered the incident. (522) [s. 104. (1) 2.]

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

Issued on this 25th day of October, 2018

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

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

Ministére de la Santé et des Soins de longue durée

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

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

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

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMIE GIBBS-WARD (630), CASSANDRA ALEKSIC (689), INA REYNOLDS (524), JULIE LAMPMAN (522), MELANIE NORTHEY (563)
Inspection No. / No de l'inspection :	2018_722630_0019
Log No. / No de registre :	023242-18
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 23, 2018
Licensee / Titulaire de permis :	Caressant-Care Nursing and Retirement Homes Limited 264 Norwich Avenue, WOODSTOCK, ON, N4S-3V9
LTC Home / Foyer de SLD :	Caressant Care Woodstock Nursing Home 81 Fyfe Avenue, WOODSTOCK, ON, N4S-8Y2
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Debbie Boakes

To Caressant-Care Nursing and Retirement Homes Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee must be compliant with s. 6. (7) of the LTCHA.

Specifically the licensee must:

a) Ensure that the care set out in the plan of care related to mobility and falls prevention is provided to the resident as specified in their plan.

b) Ensure a monitoring process is developed and fully implemented, including the staff responsible for monitoring, to ensure that the plan of care for residents at moderate or high risk for falls are being provided to the residents as specified in their plan. This monitoring process must be documented.

Grounds / Motifs :

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

This inspection was initiated as a result of a Critical Incident System (CIS) report submitted to the Ministry of Health and Long-Term Care (MOHLTC) regarding a fall for an identified resident.

Review of the clinical record for this resident showed that the resident required a specific type of care related to transfers and mobility. The plan of care indicated the resident used a specific device for mobility. A progress note and assessment report stated that this specific device had been removed from the resident's room and shortly after the resident sustained a fall.

During an interview a Registered Nurse (RN) said that they remembered the

incident and that it occurred on a day when they were short of staff. The RN said the resident was left in their room without their specific device and was not monitored. The RN said that when this device was removed from the room then the resident should have been monitored and should not have been left alone. The RN said that staff could also have replaced the device with another.

During a staff interview with a Resident Care Coordinator (RCC) said that an external service provider had removed the resident's device from their room for cleaning and staff were not aware. The RCC agreed that if a resident required their ambulation device as per plan of care then it should have been readily available.

The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan. (524) [s. 6. (7)]

The severity of this issue was determined to be a level 3 as there was actual harm. The scope of the issue was a level 1 as it was related to 1 out of 3 residents reviewed. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 17, 2018 (2018_606563_0001);
- WN and VPC issued August 24, 2017 (2017_605213_0017);
- WN and VPC issued June 29, 2017 (2017_605213_0007);
- WN and Compliance Order (CO) issued January 25, 2017 (2016_303563_0042). The CO was complied May 23, 2017 (2017_605213_0007);
- WN and VPC issued October 20, 2016 (2016_326569_0021). (524)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 002

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

Linked to Existing Order / Lien vers ordre existant: 2018_508137_0017, CO #001;

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)(b).

Specifically the licensee must:

a) Ensure the "Hot Weather Plan - Residents" and "Hot Weather Plan - Taking Humidity and Temperature Readings - Residents" policies are reviewed and revised with respect to their effectiveness in meeting the needs related to hot weather related illness prevention and management. The home must keep a documented record of this review.

b) Develop and implement a documented procedure in the home to ensure that all staff receive an in-service on the hot weather related illness prevention and management policies prior to the hot weather plan coming into effect each year.

c) Ensure the revised hot weather related illness prevention and management policies are fully implemented and complied with.

Grounds / Motifs :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with.

Ontario Regulation 79/10, s. 20 (1) states, "Every licensee of a long-term care home shall ensure that a written hot weather related illness prevention and management plan for the home that meets the needs of the residents is developed in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices and is implemented when required to address the adverse effects on residents related to heat."

On July 16, 2018, during complaint inspection #2018_508137_0017, compliance order (CO) #001 was issued and ordered the licensee to take action to achieve compliance by ensuring that the home's policies "Hot Weather Plan –Staff", "Hot Weather Plan – Residents" and "Hot Weather Plan – Taking Humidity and Temperature Readings – Residents" were complied with. This order was to be complied on July 31, 2018.

CO #001 issued in inspection #2018_508137_0017 stated:
"The licensee must be compliant with O.Reg.79/10, s.8 (1)(b).
Specifically the licensee must:
a) Ensure that staff receive an in-service of the hot weather plan and to include but not limited to the signs and symptoms of heat stress, causes, risk factors, controls and preventions.
b) Ensure that all residents have a completed and updated heat assessment on file.
c) Ensure the documentation is completed on the Humidex recording forms, at the start of each shift, and that daily monitoring takes place to ensure the process is being followed."

A review of the home's Hot Weather Plan – Residents and Staff dated July 2018, noted the following:
"The Hot Weather Plan will be in effect from May 1 to September 30 or during periods of high temperature reading (35 C) and high humidity levels.
Registered staff are responsible for taking the readings each hallway (Resident Areas).
Procedure for taking and recording Humidex:
Purpose: Timely detection of Humidex 30 or greater. Hourly recordings when Humidex is above 34 or the temperature is above 25 C."

The home's Hot Weather Plan In-service stated, "The temperature and relative humidity is taken and recorded at the beginning of each shift by the registered staff in each hallway section of the Nursing Home and hourly by the staff

working in the high risk areas (tub/shower rooms, laundry room, dishwasher rooms and kitchens)."

A) Review of the home's Hot Weather Plan - Indoor Humidex Recording Forms for August and September 2018, identified that the readings for temperature, humidity and humidex were not recorded for multiple areas in the home at multiple times in accordance with the home's policy and procedures.

During an interview a RPN stated that registered staff were responsible to record the temperature and humidity each shift and record it on the Humidex Recording form. The RPN stated if the temperature or humidity got too high then registered staff recorded the readings hourly.

During an interview, a Resident Care Coordinator (RCC) stated that registered staff were responsible for monitoring and recording the temperature, humidity and humidex on the resident home areas. The RCC reviewed the humidex recording forms and confirmed that registered staff were not consistently documenting the temperature, humidity and humidex each shift and hourly when the temperature was above 25 degrees Celsius.

During another interview a Resident Care Coordinator (RCC) stated the RCCs were to audit completion of the humidex recording forms. RCC stated they were to go around and check that staff were completing the forms but this was not documented. The RCC stated that they needed to start doing the audits and documenting that the audits were completed.

B) During interviews two identified staff stated they had just returned back to work and had not received any education on the home's Hot Weather Plan.

Review of the home's Hot Weather Plan training records noted that 11 out of 166 (6.6%) staff had not completed the Hot Weather Plan training.

During an interview the interim Executive Director (ED) stated all staff should have received training and that staff should be following the home's Hot Weather Plan policy.

The licensee has failed to ensure that the "Hot Weather Plan –Staff", "Hot Weather Plan – Residents" and "Hot Weather Plan – Taking Humidity and Temperature Readings – Residents" were policies were complied with as

required in CO #001 from Inspection #2018_508137_0017 with compliance due date July 31, 2018. (522) [s. 8. (1)]

The severity of this issue was determined to be a level 3 as there was actual risk. The scope of the issue was a level 3 as the Hot Weather Plan had the potential to affect a large number of residents. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Compliance Order (CO) issued July 16, 2018 (2018_508137_0017) with CO due date July 31, 2018.
- WN and Voluntary Plan of Correction (VPC) issued January 17, 2018 (2018_606563_0001);
- WN, CO and Directors Referral (DR) issued August 24, 2018 (2017_605213_0015). The CO was complied October 5, 2017 (2017_605213_0020);
- WN and CO issued May 24, 2017 (2016_229213_0039). The CO was closed with link August 23, 2017 (2017_605213_0015);
- WN and VPC issued January 25, 2017 (2016_303563_0042);
- WN issued August 15, 2017 (2016_229213_0035);
- WN issued October 20, 2016 (2016_326569_0021);
- WN and VPC issued November 26, 2015 (2015_426515_0030). (522)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jun 30, 2019

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

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

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 50 (2)(d).

Specifically the licensee must:

a) Ensure that an identified resident and any other resident who is dependent on staff for repositioning, is repositioned every two hours or more frequently as required depending on the resident's condition and tolerance of tissue load, and while asleep if clinically indicated.

b) Ensure there is accurate and complete documentation of the repositioning care provided by staff to an identified resident and any other resident who is dependent on staff for repositioning.

Grounds / Motifs :

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

During an interview a family member told Inspector #563 that an identified had developed multiple wounds after their admission to the home.

The clinical record for this identified resident showed that this resident had developed multiple wounds of a specific type since their admission to the home. The care plan in Point Click Care (PCC) documented to turn and re-position this resident every two hours and the resident required a specific type of assistance with bed mobility.

During an interview the RAI Coordinator provided the "Caressant Care Woodstock Documentation Survey Report v2" for a specific time period and stated that the times for PSW documentation were from 0000 hours (midnight) to 2200 hours each day and if there were blanks in documentation that it would mean that there was no documented evidence that the task was completed for repositioning every two hours.

The "Caressant Care Woodstock Documentation Survey Report v2" for this resident had the care plan task to turn and re-position resident every two hours. The Personal Support Workers (PSWs) were to document the care provided in PCC Point of Care (POC). The resident was not documented as being turned

and reposition for identified time periods over the course of five months.

During an interview the Director of Care (DOC) acknowledged that this resident had multiple wounds that had been acquired in house after admission. The DOC stated the resident was on a turning a repositioning routine every two hours since admission. The DOC looked at the "Caressant Care Woodstock Documentation Survey Report v2" for each month and acknowledged that there were multiple blanks in documentation and the PSWs did not document the completion of the task.

Based on interviews and record review, the resident was dependent on staff for repositioning every two hours related to skin integrity concerns. There was no documented evidence that the resident was turned and repositioned every two hours and the resident acquired wounds. (563) [s. 50. (2) (d)]

The severity of this issue was determined to be a level 3 as there was actual risk. The scope of the issue was a level 1 as it was related to 1 out of 3 residents reviewed. The home had a level 4 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Compliance Order (CO) issued June 29, 2017 (2017_605213_0007). The CO was complied October 5, 2017 (2017_605213_0020)
- WN issued May 24, 2017 (2016_229213_0039);
- WN and (CO) issued January 25, 2017 (2016_303563_0042). The CO was closed with link June 29, 2017 (2017_605213_0007);
- WN issued October 20, 2016 (2016_326569_0021).
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

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. 87. (2) As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee shall ensure that procedures are developed and implemented for,

(a) cleaning of the home, including,

(i) resident bedrooms, including floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and

(ii) common areas and staff areas, including floors, carpets, furnishings, contact surfaces and wall surfaces;

(b) cleaning and disinfection of the following in accordance with manufacturer's specifications and using, at a minimum, a low level disinfectant in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices:

(i) resident care equipment, such as whirlpools, tubs, shower chairs and lift chairs,

(ii) supplies and devices, including personal assistance services devices, assistive aids and positioning aids, and

(iii) contact surfaces;

(c) removal and safe disposal of dry and wet garbage; and

(d) addressing incidents of lingering offensive odours. O. Reg. 79/10, s. 87 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 87 (2).

Specifically the licensee must:

a) Ensure that procedures are developed and implemented in the home to ensure the resident bedrooms, privacy curtains, wall surfaces, floors, and common areas, including the tub rooms, are kept clean and sanitary.

b) Ensure that the procedures in the home that have been developed for the cleaning of mobility devices are fully implemented to ensure that resident #011's, #021's, #022's, #023's and #024's, and any other resident's, mobility device is kept clean and sanitary.

c) Ensure a weekly monitoring process is developed and implemented, including the staff responsible for monitoring, to ensure that the home, furnishings, equipment and residents' personal assistance services devices, assistive aids and positioning aids are kept clean and sanitary. This monitoring process must be documented.

Grounds / Motifs :

1. The licensee failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee ensured that procedures were developed and implemented for cleaning of the home, including resident bedrooms, floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, and common areas and staff areas including floors, carpets, furnishings, contact surfaces and wall surfaces; and the cleaning and disinfection of supplies and devices, including personal assistance services devices, assistive aids and positioning aids.

A) During the Resident Quality Inspection (RQI) initial tour, there were multiple common areas of the home which were observed to be unclean.

During an interview a Maintenance staff member and Environmental Service Supervisor (ESS) verified that the whirlpool room was unclean. The ESS stated it was the expectation that the whirlpool area was cleaned every day. The ESS stated that the housekeepers were responsible for cleaning the tub room floors once a day on the day shift, but was unsure who was responsible for cleaning the shower walls since nursing staff were responsible for the tubs. The ESS was also unsure how often the shelving units were cleaned, but verified that both

shelving units should be moved and cleaned underneath. The ESS stated the whirlpool tub closet was to be cleaned and acknowledged that the floors were not clean.

During an interview the Director of Care (DOC) observed the whirlpool tub closet area and verified that there were cobwebs and that the floor needed to be cleaned. The DOC also verified that there was a brown build up on walls and floor in shower stall areas.

During an interview the ESS and Inspector #563 observed the adjacent brick wall and flooring adjacent to the whirlpool tub room. The ESS verified that there were cobwebs and that the floor needed to be cleaned. The ESS stated they just recently acquired the housekeeping department as part of their responsibilities. The ESS was asked if there was a housekeeping audit in place to ensure common areas and resident rooms were being cleaned as scheduled and they said they did not know.

The Caressant Care Nursing & Retirement Homes Ltd. "Cleaning Guidelines – Tub Rooms" policy last reviewed August 2017 stated: "All tub rooms shall be thoroughly cleaned daily." The procedure included that housekeeping was responsible for wiping grab bars, pull cords and shower control with a disinfectant, to clean the outside of the tub and to dry/wet mop the floors.

The Caressant Care Nursing & Retirement Homes Ltd. "Cleaning Guidelines – Common/General Areas" policy last reviewed August 2017 stated: "Dry and/or damp mop or use Auto Scrubber to clean hallways daily."

During a follow-up interview the ESS stated the expectations for cleaning of the tub/shower/whirlpool areas was done by housekeepers and that they had been just cleaning the floors and a cleaning routine for a weekly spray down would be implemented and completed by housekeepers. The ESS stated cleaning resident rooms was done daily and the expectation for cleaning hallway floors, walls, hand rails and surfaces was that they were done once a week. The ESS also stated that ceiling and wall vents were vacuumed and cleaned for dust twice a year.

The Environmental Service Supervisor (ESS) toured the home, including resident rooms and common areas, with Inspector #563 and Inspector #721 and the ESS acknowledged multiple areas in the home which were not clean. The

ESS acknowledged that there were multiple privacy curtains in residents' rooms which were not clean. The ESS acknowledged that an identified mechanical lift was not clean.

The Caressant Care Nursing & Retirement Homes Ltd. "Cleaning Guidelines – Thorough Cleaning" policy last reviewed August, 2017, stated: "all areas of the facility must be thoroughly cleaned as per schedule." The procedure included stripping, re-waxing floors (if required) and buffing as per schedule, cleaning of inside windows, washing walls, ceilings (where possible), the removal of laundering of window curtains and privacy curtains (semi-annually or as per schedule) and thorough dusting high and low. This included washroom area as well when cleaning the resident's room.

The Caressant Care Woodstock's "Level 1 & 2 Assigned Room Clean" documented specific tasks that were to be done on an eight week rotation.

During an interview with Housekeepers they stated on a daily basis resident rooms were cleared of garbage, dusted, bathrooms including toilet, counter, sink, and mirror were cleaned and resident room and bathroom floors were washed. They stated that walls were included in the total clean of a resident's room which was done approximately every two months, otherwise it was a spot cleaning of the walls. The housekeepers stated that privacy curtains were taken down when soiled and sent to laundry, but there was no schedule for this task. They shared that the floors were mopped daily, and then a couple of days a week they used the auto scrubber and there was no routine for when the floors were cleaned with the auto scrubber. The housekeepers stated that there were four housekeepers in the home for the day shift and one student in the evening. The housekeepers verified that they cleaned the whirlpool room floor, but that the nursing staff providing the baths were to clean the shelves and everything else.

The Caressant Care Nursing & Retirement Homes Ltd. "Principal Functions" policy last reviewed August, 2017, stated the "housekeeping department cleans all residents rooms, common areas e.g. lounges, hallways, dining rooms, utility rooms, offices, as per the daily routine."

The Caressant Care Nursing & Retirement Homes Ltd. "Job Description – Housekeeping Aide" policy last reviewed May, 2017, stated, "The Housekeeping Aide is responsible for maintaining high standards of cleanliness and sanitation

throughout the facility by adherence to established work schedules, and in accordance with governmental and facility guidelines". The primary duties and responsibilities for the housekeeping aide included performing "tasks such as: stripping/waxing/buffing of floors, vacuuming, sweeping, dry/wet mopping, scrubbing, sanitizing/disinfecting floors, furniture, shelves, woodwork, bathroom fixtures, spot cleaning walls, windows and doors between washing, dusting emptying wastebaskets and rearranging furniture, replenishing supplies, cleaning utility rooms, closets etc."

The Caressant Care Nursing & Retirement Homes Ltd. "Cleaning Guidelines – Wet Mopping Floors" policy last reviewed July, 2017, stated: "All floor areas must be kept clean and free of all hazards".

During a follow-up interview the ESS acknowledged that the "Cleaning Guidelines – Tub Rooms" did not make reference to who was responsible for cleaning the tile walls in the shower areas. The ESS stated the tile walls in the tub rooms should be cleaned by the housekeeping staff, but did not know how often this would be done. The ESS stated that there were established work routines and policies for housekeeping, but that there were areas in resident rooms, hallways and tub rooms that had a build-up of dirt and debris. The ESS was asked about the "Cleaning Guidelines – Thorough Cleaning" policy last reviewed August, 2017, which stated: "stripping, re-waxing floors (if required) and buffing as per schedule". The ESS stated they were not aware of any schedule for this task.

During an interview the Corporate Environmental Services Consultant (CESC) stated it was the responsibility of the CESC, the Regional Manager, the Executive Director (ED) and the ESS to ensure housekeeping staff were completing their routines as outlined, that the home was clean and to follow up with staff to ensure those expectations were being met. The CESC verified it was the responsibility of the housekeeping department for the cleaning of the tiled shower stall walls and whirlpool room. The CESC stated the "Monthly Housekeeping Audit" was not new and has been in effect for a while and was previously completed by the ED, but the ESS was now responsible for its completion. The CESC did not know when the last housekeeping audit was completed. Inspector #563 and the CESC reviewed the home's policy titled "Housekeeping Audit" policy with last reviewed September 2018. The policy stated: "should trends develop or are noted, note which area to determine if there is a problem with staff or a procedural problem that requires housekeeping

in-service." The CESC stated the ESS was responsible for following up with staff and the CESC was responsible for providing the housekeeping in-service. The CESC verified that an in-service had not been provided. The CESC also stated that when they were present in the home they subtlety watch one or two housekeepers clean a resident room, but there was no documentation of this housekeeping inspection.

During a follow-up interview the ESS stated that there was no housekeeping audit done and they thought that the monthly housekeeping audit was newly implemented.
During an interview the Executive Director (ED) stated the home could not locate the last housekeeping audit completed. The ED stated that in speaking with ESS they believed the audit was not done. (563)

B) During stage 1 of the RQI multiple residents by multiple inspectors were observed to have unclean ambulation equipment.

During follow-up observations five identified residents were observed by Inspector #563 to have unclean ambulation equipment.

During an interview with a PSW they acknowledged to Inspector #563 that these residents had unclean ambulation equipment.

The clinical record for two of the identified residents did not include cleaning of the ambulation equipment. The clinical record for two other of the identified residents indicated that staff had documented that they had cleaned the ambulation equipment within the past week. The clinical record for one other of the identified residents indicated that the staff had documented that they had not cleaned the ambulation equipment when it was scheduled.

During an interview the Director of Care (DOC) stated the cleaning of resident ambulation equipment was done by PSWs on the night shift, and that there was a routine and job description for that. The DOC stated that each wheelchair should definitely be wiped down each night with a Virox wipe and verified that the cleaning of ambulation equipment did include the wheels, foot rests, cushions and head rests. The DOC verified that two of the residents did not have a routine for cleaning as part of their plan of care. The DOC stated there was POC documentation that one of the identified residents just had their ambulation equipment cleaned. The DOC and Inspector #563 then observed

this resident's ambulation equipment for a build-up of debris and dust on wheels, brakes, and armrests. The DOC verified the ambulation equipment was not cleaned as documented for this resident. The DOC also verified that the ambulation equipment for three identified residents were not cleaned and had a build-up of dirt and dust.

The Caressant Care Nursing & Retirement Homes Ltd. "Commodes, Wheelchairs, Lifts – Cleaning Guidelines" policy last reviewed June, 2018, stated: "All equipment will be cleaned and well maintained. All wheelchairs, walkers, gerichairs, lifts & shower chairs are to be cleaned weekly by the PSW's". The procedure in this policy stated, "resident's with personal seat covers are to be removed, sent to laundry for washing, air dried and reapplied before morning."

Based on observations, staff interviews and record review of policies and procedures related to housekeeping, the licensee failed to ensure that procedures were implemented for cleaning of the home. The Environmental Service Supervisor acknowledged multiple resident bedrooms, bathrooms, floors, privacy curtains, contact surfaces and wall surfaces were not clean. The Director of Care acknowledged five residents had ambulation equipment and positioning aids that had a build-up of dirt, dust and debris and were not cleaned. The DOC also acknowledged that for two of the five residents, the cleaning of their ambulation equipment was not a part of their plan of care. (563) [s. 87. (2)]

The severity of this issue was determined to be a level 2 as there was potential for actual risk. The scope of the issue was a level 2 as it was a pattern. The home had a level 3 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) issued January 17, 2018 (2018_606563_0001). (563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 90. (1) As part of the organized program of maintenance services under clause 15 (1) (c) of the Act, every licensee of a long-term care home shall ensure that,

(a) maintenance services in the home are available seven days per week to ensure that the building, including both interior and exterior areas, and its operational systems are maintained in good repair; and

(b) there are schedules and procedures in place for routine, preventive and remedial maintenance. O. Reg. 79/10, s. 90 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 90. (1)(b).

Specifically the licensee must:

a) Ensure that schedules and procedures are developed and fully implemented for routine, preventive and remedial maintenance for resident rooms and common areas in the home.

b) Ensure their "Preventative Maintenance of Mechanical Lift" policy is complied with.

c) Ensure accurate and complete documentation is maintained in the home of the completion of the routine, preventive and remedial maintenance for resident rooms, common areas and equipment, including mechanical lifts.

d) Ensure all maintenance services program staff and management are trained on the schedules and procedures for routine, preventive and remedial maintenance, including the documentation procedures. The home must keep a documented record of the education provided.

e) Ensure a weekly monitoring process is developed and fully implemented, including the staff responsible for monitoring, to ensure that the home, furnishings and equipment are kept in good repair. This monitoring process must be documented.

Grounds / Motifs :

1. The licensee failed to ensure, as part of the organized program of maintenance services under clause 15 (1) (c) of the Act, that there were schedules and procedures in place for routine, preventive and remedial maintenance.

A) During Stage One of the RQI, Inspectors #563, #689 and #721 noted disrepair in resident rooms and bathrooms. The Environmental Service Supervisor (ESS) toured the home on a specific date, including resident rooms and common areas, with Inspector #563 and Inspector #721 and the ESS verified that there were multiple areas of disrepair in common areas and resident rooms.

During an interview the Environmental Service Supervisor (ESS) verified that

there were no schedules and procedures in place that they were aware of for remedial maintenance of walls, floors and bathrooms. The ESS verified that a room audit for maintenance disrepair was not being completed at this time and acknowledged they were unaware of the disrepair in the home at this time, other than what was in the Maintenance Care online reporting system. The ESS verified that all staff had access to the reporting system, but that staff do not report all areas of concern and therefore the ESS did not know about them. The ESS stated that previous Executive Directors had completed the resident room audits, but the ESS was unable to locate the documentation.

During a follow-up interview the Environmental Service Supervisor (ESS) stated that quarterly each resident room was reviewed for painting or repair needs and acknowledged and that the Corporate Environmental Service Consultant would be completing this. The ESS stated a schedule was just created in Maintenance Care for the painting of resident rooms and common areas. The ESS verified that there was no schedule as part of the preventative maintenance program for remedial maintenance related to painting and drywall repair before the day of the interview. The ESS stated the new biweekly general room repair schedule included common areas that would be done quarterly. The schedule did not include hallways, but lounges, kitchens and dining rooms have been added.

During an interview the Corporate Environmental Services Consultant (CESC) stated the home was ensuring areas of disrepair were being addressed by developing an action plan and completed quarterly. The CESC stated they looked at baseboards, wall damage, sinks that need to be repaired, and toilets that needed to be caulked for example. The CESC stated that the home did conduct their own inspections or audits of resident rooms quarterly and were completed by the CESC for all resident rooms. The document titled "Caressant Care Preventative Maintenance Program Resident's Rooms/Common Areas Action Plan" was reviewed and the CESC stated the form was used to support the "Preventative Maintenance Program for Resident's Rooms / Common Areas" policy. The CESC stated the form was last completed in August 2018. The document asked for the room number, item to be addressed and who it was reviewed by. The CESC was asked what was done with the information collected after the completion of the audit in August 2018 and they replied that the document was scanned and sent to the Executive Director by email. The document was then supposed to be reviewed by the Executive Director and tracked to ensure the work was completed and for follow up with the maintenance staff. The CESC acknowledged that the August Action Plan for

preventative maintenance of resident rooms / common areas was not dated or documented as reviewed by anyone. The Corporate Environmental Services Consultant (CESC) stated they were now responsible for doing the quarterly maintenance inspections.

During an interview the Executive Director (ED) verified that the quarterly Action Plan for August was never provided to them and the ED had not reviewed it and does not have a copy of it. The ED was unsure if the previous quarterly Action Plan was completed for May 2018.

Based on observations, staff interviews and record review of policies and procedures related to the preventative maintenance for resident rooms and common areas, the licensee failed to ensure that there were schedules in place for remedial maintenance. (563)

B) Complaint #IL-59214-LO was submitted to the Ministry of Health and Long-Term Care (MOHLTC) which stated residents were not getting the care that they need as there was broken equipment such as lifts, and they were not being repaired or replaced.

Review of the home's Preventative Maintenance of Mechanical Lift policy, reviewed date August 2017, noted the following:
Maintenance Staff shall:
1. Maintain all equipment in safe operating condition.
2. Complete monthly lift inspection and document using the Lift Inspection Log
3. Ensure an annual lift inspection is completed by a qualified contractor.

A review of the home's repair logs for mechanical lifts noted that there was no documented evidence to support that mechanical lifts were being inspected monthly.

During an interview the Environmental Services Supervisor (ESS) acknowledged that not all mechanical lifts were inspected monthly. The ESS stated that most lifts come down for maintenance monthly so they saw most lifts. When asked if there was a schedule in place to ensure all lifts were inspected monthly, the ESS stated that there was no schedule in place for monthly inspections of mechanical lifts.

During an interview the Interim Executive Director stated that all mechanical lifts

should be inspected monthly and there should be a schedule in place for monthly inspections of mechanical lifts.

The licensee has failed to ensure that as part of the organized program of maintenance services, there were schedules and procedures in place for routine, preventive and remedial maintenance. (522) [s. 90. (1) (b)]

2. The licensee has failed to ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications, at a minimum.

Complaint #IL-59214-LO was submitted to the MOHLTC which stated residents were not getting the care that they need as there was broken equipment such as lifts, and they were not being repaired or replaced.

Review of the home's Preventative Maintenance of Mechanical Lift policy, reviewed date August 2017, noted the following:
Maintenance Staff shall:
1. Maintain all equipment in safe operating condition.
2. Complete monthly lift inspection and document using the Lift Inspection Log
3. Ensure an annual lift inspection is completed by a qualified contractor.

A) During an interview the Environmental Services Supervisor (ESS) stated that the home had 24 lifts in service in the home. The ESS stated that from June 2018, until present there had been 23 lift repairs. When asked how long each lift was out of service during the repairs, the ESS was unable to determine how long each lift was out of service. The ESS stated that the home used an electronic system called Maintenance Care for staff to enter mechanical lift repairs. The ESS stated maintenance may have completed a repair in a day but the work order may not be closed off in Maintenance Care for several days so there was no way to determine how long a lift may have been out of service. The ESS also stated that repairs were still hand written in the lift repair log and if the repair was documented in the lift repair log maintenance did not track the length of time the lift was out of service.

A review of the home's repair logs for mechanical lifts noted that there was no documented evidence to support that mechanical lifts were being inspected monthly.

During an interview the ESS acknowledged that not all mechanical lifts were inspected monthly. The ESS stated that all lifts in the home received an annual inspection in May 2017, from Care-Med Health Systems.

B) A review of the home's annual lift inspections noted that there were six lifts that did not have an annual lift report from Care-Med Health Systems. The ESS stated if there was no annual report there would be a maintenance inspection sticker on the lift to show there was an annual inspection of the lift in 2017.

During an interview the ESS and Inspector #522 reviewed the lifts on the floor to determine if there was a maintenance inspection sticker from Care-Med Health Systems on the lifts. During this interview it was observed that multiple lifts did not have an inspections sticker on them or the inspection sticker was illegible. The ESS and a maintenance staff member reported that there were three lifts out of service at the time of the interview. The ESS said they did not know how long one of the lifts had been out of service. The ESS also said that there was one lift that was listed that had been replaced with a new lift and therefor they thought that lift did not require an annual inspection. The ESS stated that when the lift was replaced they kept the same lift number and service log as the previous lift. Inspector #522 asked when the lift was replaced and the ESS stated they did not know but thought it was within the year. There were no notes in the service log or the maintenance lift tracking sheet to support that the lift was replaced.

C) During an observation in a specific area, Inspector #522 observed a lift with a maintenance inspection sticker from Care Med Health Systems. The area for date and initials was blank. A maintenance staff confirmed there was a sticker on the lift but there was no date or initials.

A review of the annual lift report from Care-Med Health Systems for this lift noted the lift had failed inspection on in May 2017. A review of the repair log for the lift noted an entry in September 2016, which noted that the rear castors were replaced and no further repairs noted until October 2017, which noted the emergency stop button was replaced. There were no noted repairs after the annual inspection noted the lift had failed inspection.

During an interview Inspector #522 asked the ESS why this lift had failed inspection, what repairs were completed and how long the lift was out of service.

The ESS was unable to provide this information. The ESS stated that the lift was repaired since it was currently being used.

During an interview the interim Executive Director (ED) stated that all lifts should be inspected monthly and have an annual inspection on the anniversary of the previous inspection. The interim ED stated that the lift that was put into service in January 2017, should have had an annual inspection. The interim ED stated that the completion of service and repairs on lifts needed to be documented appropriately.

The licensee has failed to ensure that procedures were developed and implemented to ensure that electrical and non-electrical equipment, including mechanical lifts, were kept in good repair, and maintained and cleaned at a level that met manufacturer specifications, at a minimum. (522) [s. 90. (2) (a)]

The severity of this issue was determined to be a level 2 as there was potential for actual risk. The scope of the issue was a level 3 as it represented a systemic failure that had the potential to affect a large number of residents. The home had a level 3 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN) and Compliance Order (CO) issued November 26, 2015 (2015_416515_0030). The CO was complied September 19, 2016 (2016_326569_0021).
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

Order # / Ordre no : 006

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 two identified residents and any other resident of the home in accordance with the directions for use specified by the prescriber.

b) Ensure the Director of Care (DOC) as well as all Registered Practical Nurses (RPNs) and Registered Nurses (RNs) who administer medication in the home are trained on the appropriate administration of "as needed" insulin in accordance with the directions for use specified by the prescriber. The home must keep a documented record of the education provided.

c) Ensure the Director of Care (DOC) as well as all Registered Practical Nurses (RPNs) and Registered Nurses (RNs) who administer medication in the home are trained on the home's policies and procedures, including the Medical Directives, related to capillary blood sugar checks (glucometer). The home must keep a documented record of the education provided.

d) Ensure that the plan of care related to capillary blood checks (glucometer) for an identified resident and any other resident with an as needed insulin order, is reviewed and revised to meet the needs of that resident.

Grounds / Motifs :

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

A) A Medication Incident - Original Report for an identified resident documented that Medical Pharmacies had received a fax which was not processed regarding the order to hold a specific medication for a specific amount of time. The original order dated was never received by the pharmacy and the facility staff did not follow up on a new order to ensure it had been processed. Pharmacy was unaware that the order existed until a fax was received three days later.

The Caressant Care Nursing Home Woodstock - 2018 Medication Error Analysis documented the physician faxed to hold the medication then decrease the dose. The night nurse faxed this to pharmacy but the order was not processed. As a result, the change was not entered into the electronic Medication Administration Record (eMAR). Pharmacy called to alert the nurse of the error and the nurse faxed a new order, but did not put note on the strip package to alert others of the change in dosage of this medication.

The "Fax Cover Sheet" from the physician documented that this medication was to be held and then restarted at a different dose.

The eMAR for documented that this identified resident was administered the medication by mouth at a specific dose daily during the three days after the physician had ordered it to be held.

The "Fax Cover Sheet" from the physician documented that they had sent fax to hold the medication but pharmacy not aware. The physician advised that the medication was then to be held for a specific time period and then restarted at a specific dose.

The eMAR then documented that this resident was not administered the medication for three days and then was administered to the resident at a different dose then had been ordered by the physician.

During an interview the Director of Care (DOC) verified that the medication was not held as had been ordered and the order was not administered in accordance with the directions for use specified by the prescriber.

The licensee failed to ensure that the medication was administered to this resident in accordance with the directions for use specified by the prescriber.

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

The Infoline - Complaint Information Report #IL-59700-LO documented complaints related to the care of an identified resident. The complainant reported concerns regarding the administration of a specific medication.

The electronic Medical Directives Record (eMDR) for a specific time frame directed that a specific type of test was to be done as needed. There was no documentation that this testing had been completed for this identified resident.

The electronic Medication Administration Record (eMAR) in PCC for specific time frames showed that the specific medication had not been administered as per the physician's orders.

During an interview the Director of Care (DOC) stated the order for the specific test meant the nurses could do the test like an as needed (PRN) order. The DOC stated that there was no documentation of this testing having been done for a specific time period. The DOC also acknowledged that the specific medication for this resident had not been given as prescribed on specific dates.

The licensee failed to ensure that this specific medication was administered to this identified resident in accordance with the directions for use specified by the prescriber. (563) [s. 131. (2)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 2 as it was related to 2 out of 5 residents reviewed for medication administration. The home had a level 5 history as they had on-going noncompliance with this section of the LTCHA that included:
- Written Notification (WN), Compliance Order (CO) and Director's Referral issued October 6, 2017 (2017_605213_0020). The CO was complied November 27, 2017 (2017_606563_0023);
- WN, CO and DR issued August 24, 2017 (2017_605213_0015). The CO was closed with link on October 6, 2017 (2017_605213_0020);
- WN and CO issued June 29, 2017 (2017_605213_0008). The CO was closed with link on August 23, 2017 (2017_605213_0015);
- WN issued May 24, 2017 (2016_229213_0039);
- WN and Immediate CO issued January 24, 2017 (2016_229213_0035). The

CO was complied November 27, 2017 (2017_606563_0023).
(563)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 30, 2018

Order # / Ordre no : 007

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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) Develop, document and implement a process in the home for the leadership to monitor variances from the written staffing plan related to vacant RN, RPN and PSW shifts.

b) Develop, document and implement a process in the home for the leadership to monitor and evaluate, at least weekly, whether the written staffing plan is meeting the care and safety needs of the residents, including the accurate and complete documentation of the care provided to residents.

c) Ensure the written staffing plan, including the back-up plan, is reviewed and revised to ensure it is meeting the care and safety needs of residents. The home must keep a documented record of the review including the names of the people who participated in the review.

d) Ensure the Executive Director (ED), Director of Care (DOC), Assistant Director of Care (ADOC), all Resident Care Coordinators (RCCs), all Ward Clerks, all RNs, all RPNs and all PSWs are trained on the revised staffing back-up plan. The home must keep a documented record of the education provided.

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

Grounds / Motifs :

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

O. Reg. 79/10, s. 31 (2) states that every licensee shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b).

O. Reg. 79/10, s. 31 (3) states that 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 (4) states that the licensee shall keep a written record relating to each evaluation under clause (3) (e) 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.

Specifically the licensee did not comply with the following:
- The home's staffing plan with documented implementation date May 2018.
- The home's policy titled "Staffing Plan/Reassignment of Duties" with effective date February 2018 and reviewed date February 2018.
- The actions and plans identified in the Caressant Care "Quality Program Evaluation NSGPSW Staffing Plan" dated November 14, 2017.

The Home's written "Staffing Plan" dated August 2018 indicated the following staffing levels for 163 residents:
- PSWs: 18 total for day shift per day; 12 total for evening shift per day; 8 total for night shift per day; total 38 per 24 hours period.
- RPNs: 3 total for day shift per day; 3 total for evening shift per day; 1 total for night shift per day; total 7 per 24 hours period.
- RNs: 3 total for day shift per day; 2 total for evening shift per day; 1 total for night shift per day; total 6 per day.

The home's policy titled "Staffing Plan/ Reassignment of Duties" with effective date February 2018 and reviewed date February 2018. This policy included:
- "Caressant Care will ensure that staffing levels are effective so that each resident will receive individualized personal care, including hygiene care and grooming on a daily basis."
- "If the home is required to work short the registered staff will reassign/prioritize duties as needed."
- "When possible the home will reschedule any missed shifts to catch up on any

duties that did not get completed on the previous shift for example bath shifts."
- "Appendix One: Vacant Position: PSW/HCA; Vacant Shift: Days and Evenings; Plan Strategy: Call all available PSW/HCAs, bring staff in early to stay late, reassign staff i.e. bath shift to regular shift, reassign residents to available PSWs; Duties that must be done: ADL's, baths, POC documentation, feeding in the dining rooms and distribution of snacks."
- "Low Staffing Shift Routine Guidelines" included "Priorities: 1. Safety rounds every hour are top priority; 2. Checking, changing and toileting; 3. Getting residents to and from meals and feeding; 4. Answering callbells."

The "Quality Program Evaluation NGSPSW Staffing Plan" dated November 14, 2017, included:
- "Summary of changes made over the past year: Implementation of Attendance Management and Performance Management."
- "Were program objectives met? No"
- "List of Actions/Areas of Improvement" included "enhanced focus on recruitment and retention; orientation program; ensuring vacancies are filled as they become vacant; continued consultation with VP or HR regarding potential schedule changes in 2018."
- "If needed has an action plan be developed? N/A"

During an interview the DOC provided a summary of the staffing shortages for July, August and September 2018. These summaries showed the following staffing shortages:

Personal Support Workers (PSWs):
- 59 partial shifts short and 24 full shifts short with 28/31 calendar days short at least one PSW staff for July 2018.
- 84 partial shifts short and 63 full shifts short with 30/31 calendar days short at least one PSW staff for August 2018.
- 30 partial shifts short and 14 full shifts short with 16/17 calendar days short at least one PSW staff for September 2018.

Registered Practical Nurses (RPNs):
- 6 partial shifts short and 4 full shifts short with 10/31 calendar days short at least one RPN staff for July 2018.
- RPNs: 5 partial shifts short and 12 full shifts short with 10/31 calendar days short at least one RPN staff for August 2018.
- RPNs: 0 partial shifts short and 3 full shifts short with 3/17 calendar days short at least one RPN staff for September 2018.

Registered Nurses (RNs)
- 1 partial shifts short and 13 full shifts short with 14/31 calendar days short at least one RN staff for July 2018.
- 2 partial shifts short and 18 full shifts short with 15/31 calendar days short at least one RN staff for August 2018.
- 4 partial shifts short and 9 full shifts short with 9/17 calendar days short at least one RN staff for September 2018.

A) The Ministry of Health and Long-Term Care (MOHLTC) received complaint log #008204-18 which identified an anonymous concern that a specific resident did not receive a bath or shower for nine days and that the resident was told that the staff did not have time to provide that care.

During an interview this resident told Inspector #630 that there was a specific period of time after they moved into the home when did not receive a bath or shower. This resident said they did have a concern about the bathing care that they were receiving in the home and that it seemed that there were not enough staff available to provide the care needed. This resident said they had a specific preference related to the type of bathing care they received.

During an interview a PSW said they were familiar with this resident. This PSW said that it was expected that residents would be provided with two baths or showers per week. The PSW said they document in Point of Care (POC) when a resident has been given a bath or a shower and whether a resident had refused that care. The PSW said that this resident preferred to have a specific type of bathing care and required assistance from staff with bathing care.

The clinical record for this resident showed that the first documented shower that resident received in the home was 14 days after admission, the first documented bed bath that the resident received in the home was 17 days after admission and the first documented tub bath that the resident received was 22 days after admission. The plan of care for this resident identified they preferred a specific type of bathing care. The Point of Care (POC) report for specific time periods showed that this resident had not received their preferred type of bathing care five out of 22 of their designated bathing days.

During an interview a RCC told Inspector #630 that it was the expectation in the home that residents would receive two baths or showers per week of their

preferred type and their preferred time in terms of days or evenings. The RCC acknowledged that the home had been working without the full complement of PSW staff over the past three months and that they had been trying to ensure the residents had been receiving their required bathing care during that time. The RCC and Inspector #630 reviewed the POC documentation for this resident and the RCC acknowledged that there was a fourteen day period after admission where this resident did not receive their preferred bathing care as per the documentation. The RCC said that it was the expectation in the home that documentation would be completed to reflect the care provided and that they told staff that if it was not documented then it was not completed.

B) The MOHLTC received complaint log #021373-18 which identified a concern regarding short staffing in the home. This complaint said that there were residents in a specific area of the home who were not getting the care that they wanted due to lack of staffing.

The MOHLTC received complaint log #014091-18 which identified a concern regarding short staffing in the home. This complaint said that there was a regular shortage of staff including registered nursing staff and there residents were "suffering."

During an interview Inspector #630 spoke with the complainant who indicated they were a staff member who wished to remain anonymous. This complainant said that it was hard to get the residents' care done when they were working short. The staff member said that usually there were three PSWs on the shift and there had been multiple times when there were only two staff. The staff member said it was affecting the residents as they tried their best and work the entire shift to try to make sure residents are getting the care they needed but it was affecting toileting and the feeding assistance provided to residents. The staff member said that they thought the management in the home were aware of the concern. The staff member said that the home had been offering overtime but no one wanted to work overtime when the home was short as it was like doing double the work.

C) The MOHLTC received complaint log #020991-18 which identified a concern regarding chronic understaffing and that the residents were not being treated well. This complainant indicated that the "LTC administration are aware of the issue but administration had not tried to resolve the issue due to short staffing."

During an interview with a family member for an identified resident they expressed they had concerns with staffing levels in the home. The family member said that they did not think there were enough PSWs to care for the residents. The family member said that staff were rushed with bathing and there were residents, including their family member, who were not receiving their baths. This family member said they had brought forward this concern to the management and Corporate management for the home. The family member said that they received a response from the CC Director of Regional Operations who indicated they were trying to hire more staff and that there was a PSW shortage. The family member said they were not satisfied with the response to the concern as they thought that nothing had really improved. The family member said that the staff in the home worked very hard and were "really good" and "kind" but they were concerned and saddened by the shortages and other families have expressed concerns as well.

During an interview the interim Executive Director (ED) provided a written letter from a family member for an identified resident with a specific date. This letter identified concerns with the staffing shortages in the home. The interim ED also provided a written letter of response from the CC Director of Regional Operations and this letter stated "the home has been experiencing some staffing shortages due to some vacant lines and staff vacation." This letter also stated "the home is also reviewing the staffing pattern to ensure there is adequate staff on the floor at all times. The home recently created some permanent fulltime lines and are in the process of reviewing the job duties to ensure that the residents care needs are all met."

During an interview a PSW said that this identified resident required a specific level of assistance from staff with care. The PSW said that it was the expectation in the home to document the care provided to residents and if a resident refused care that would be reported and documented. The PSW said that this resident did refuse care from staff four to five times a week and they would try to reapproach.

The clinical record for this identified resident showed that they required specific types of assistance from staff with care. The Point of Care "Documentation Survey Report v2" for this resident showed that for specific time periods there were specific types of care that were not documented as having been completed.

During an interview the Director of Care (DOC) told Inspector #630 that they had started working in the home and in the DOC position recently. The DOC said that the home had needed to use the staffing back-up plan over the past three months related to staff shortages for PSWs, RPNs and RNs. The DOC said that the expectation in the home was that the staff were following the "Staffing Plan/Reassignment of Duties" when working short and it was the expectation was that care would be provided as per the residents' care needs as outlined in the plan. The DOC said that it was the expectation in the home that documentation of the care provided would be completed. When asked if the staff had been able to complete the required documentation on residents as part of their shifts, the DOC said absolutely not and that it had been an ongoing issue before they started in the role. The DOC said that they if care was not documented then it was not considered to be done.

During an interview a Registered Nurse (RN) told Inspector #630 that there had been times in the past three months when the home had been working short PSW and registered staff. The RN said that the home had been very short staffed at times and three to four times a week they were working short PSWs. The RN said that they the management was doing their best to try to hire more staff. The RN said that when they were short staff they would need to move staff around in the home and management and other disciplines would help pitch in to care for the residents. The RN said they thought there was a policy on how to manage the back-up plan at the ward clerk's desk. The RN said that it was hard when they were working short as the residents were vulnerable and the staff did their best to meet their care and safety needs. The RN said that when they were working with a full complement of staff then they felt they were able to meet the care needs of the residents.

During an interview the interim Executive Director (ED) told Inspector #630 that they had just started in the role the day before on an interim basis. The interim ED said that they had not personally been involved in responding to the letter but did have a copy of the letter and had reviewed this documentation. The interim ED said that in the letter of response the CC Director of Regional Operations acknowledged in the letter that the home had been short staffed and that they we retaking actions to hire new staff and review the job duties. The interim ED said the home had been short staffed over the summer.

D) During Stage one of the RQI the family member for an identified resident said that they were concerned that the home was short staffed all the time and that

their family member had to wait for assistance from staff regularly during a specific time period. The family member told Inspector #630 that they visited the home regularly and provided assistance to the resident and required assistance from staff with specific types of care for this resident.

The clinical record for this resident showed that they required specific types of care from staff. The Point of Care "Documentation Survey Report v2" for this resident for a specific time period showed that specific types of care had not been documented as having been completed.

During an interview a PSW said that this resident's family had requested assistance with specific types of care for this resident. The PSW said that the resident required assistance from staff. The PSW said that they had concerns with staffing shortages in the home. The PSW said that when fully staffed each wing had an average of nine to ten residents per PSW for care. The PSW said it was difficult to getting the residents up, portering to meals and doing morning and most residents required two staff for assistance.

During an interview the Director of Care (DOC) said that it was the expectation in the home that residents would be positioned at least every two hours in the home for offloading and to prevent skin breakdown and this reposition was to be documented by the PSWs in PCC. The DOC acknowledged to Inspector #630 that it was difficult to determine if repositioning had been done for this resident based on the documentation in PCC.

During an interview another PSW told Inspector #630 that there have been times in the past three months when they have been working short staffed. When asked what the staff would do when working short do determine how to manage the shortage, the PSW said they would talk among themselves and try to go where the need was higher. The PSW said there was no set plan on what to do when they were short. The PSW said that when they were short they tried to ensure that all the care was provided to residents but they did not always have time to complete the charting and sometimes residents had to wait for care or wait for the lift.

E) During an interview a PSW said that they would know what care a resident requires with dental care by the plan of care and asking the resident. The PSW said they were familiar with an identified resident and that this resident required a specific type of assistance from staff to clean their teeth. This PSW also told

Inspector #630 that this summer the home had been short staffed and it had been hard to keep up with the demands of the resident. The PSW said that lot of staff had been working time and a half and double time and they were having a hard to get the charting done. The PSW said they thought that the bare necessities of care were getting done. The PSW said the home had been short registered nursing staff as well as PSWs. The PSW said that sometimes they had been short two staff on a shift and working with one modified and the modified would do tasks like the nourishments. The PSW said that sometimes that meant there were two PSWs for 42 residents and resident having to wait for toileting. The PSW said that when the two staff go on break for 30 minutes was only the modified PSW on the floor at times. When asked if there was a routine to follow when they were short, the PSW said that it was an informal process on how to help one another in each area. The PSW said that they had brought their concern to the attention of the management staff.

During an interview this identified resident told Inspector #630 that they required a specific type of assistance from staff to clean their teeth. When asked if the staff assisted them to brush their teeth, the resident said that the staff helped them last night but not that morning.

During an interview another PSW said that they did provide care for the resident that morning and that they washed resident's mouth with a swab as they received care at night and so the staff do not need to do it in the morning. When asked if the resident had a toothbrush or toothpaste in their room the PSW said that they did not and that they did not complete the care for resident that morning and they were not aware of who provided that care.

During an interview another PSW said that they had started their shift after 0700 hours and had been called in for the shift. The PSW said that some of the morning care for residents was provided by night shift staff who stayed later. The PSW said they did not provide morning care to the resident.

During an interview another PSW said that they did not provide morning care for this resident as this was not one of their assigned residents. This PSW said they thought it might have been a different PSW.

The clinical record for this resident indicated that they required assistance from staff with dental care. The documentation in the Point of Care (POC) task "Oral Care provided as per RCP" for a specific time period indicated that oral care had

not been provided on (3/30 days or 10 per cent) for one month and had only been provided once per day on 19/30 (63.3 per cent) of the days.

During an interview an agency RPN told Inspector #630 that they had been working in the home intermittently over the past year as a RPN through an agency called Staff Relief. The agency RPN said that for some periods of time they would have no shifts and then another four shifts in one week. When asked which PSWs provided care to this identified resident that morning the agency RPN said that they did not know as there were three or four staff in that area. The agency RPN said that the home was short staffed that day and that at the start of the day shift they had staff from night shift stay longer and they thought they were short for a period of time. When asked what the process was when there was a shortage of staff for determining what care was to be done they said they thought it would depend on the residents' care plans but was not aware of a specific process.

During an interview the Director of Care (DOC) told Inspector #630 that staff would know the care a resident required related to oral care from the resident's care plan. The DOC said that when the staff started their shift they had a shift assignment and they had a routine and they generally had consistent residents. The DOC said that the PSWs were expected to be assisting with oral care once daily in the morning. The DOC said that the expectation was that the staff would be documenting the care they were provided in POC. When asked what the expectation was for staff regarding the care provided to this resident, the DOC said they should at least make sure the resident had everything they needed.

During a follow-up interview this identified resident told Inspector #630 that they needed assistance from staff to use the toilet and there were times when they have had to wait up to an hours for assistance with this care.

The clinical record for this resident showed they required specific types of assistance from staff with continence care. The Point of Care "Documentation Survey Report v2" for this resident showed the task "Toileting per RCP" was not documented as having been completed at specific times. The task "personal hygiene as per RCP" was not documented as having been completed at specific times. No bathing care documented as having been provided for a specific time period.

During a follow-up interview a PSW said that this resident needed specific

assistance from staff with care. The PSW said that this resident was able to call for assistance when they needed help. This PSW said they were not aware of times when resident had not received the care required but there were times when the resident had to wait for care when there were staff shortages.

F) During an interview a RN told Inspector #630 that there had been times in the past three months when there have been PSW shifts that had not been filled and that happened almost daily for PSWs. When asked if there was a process to direct staff how to adjust their work routines when that happened, the RN said that it was typically up to the charge nurse to make the decision and sometimes that would be the night RN as the day RN shift did not start until 0700 hours. The RN said the charge nurse would direct the staff where to go and typically would not pull staff from an area that was already short. The RN said that the home had also been short registered nursing staff almost daily. The RN said that they felt that residents' care had been affected by the staff shortages such as residents not being put to bed for morning or afternoon rests, toileting not getting done promptly, the amount of time available for assisting residents with eating in the dining room, the registered staff not having as much time to spend with the residents to answer questions. The RN said that staff had been going without breaks and staying overtime to provide the care. The RN said that sometimes the Resident Care Coordinators (RCCs) have had to step in at times to assist with assessments and care.

During an interview a RCC told Inspector #630 that there had been staff shortages in the home. The RCC said this was related to staff vacations, leave of absences and resignations. The RCC said they had been recruiting PSW staff but there remained about four PSW lines that were empty. When asked if there had been residents in the home who have not received their preferred type of bathing care twice per week in the past three months, the RCC said they had back-up plans if running short and they would try to have extra staff come in the next day to make up baths. The RCC said the home had been struggling and they personally had assisted in the tub room on several occasions helping them the PSWs to do the care. RCC #139 said they thought there was a tracking form for deferred care but was not sure if it was being used. The RCC said that they believed that the work was being done but the documentation wad not getting completed at times when working short. The RCC said that they told the staff that if the care was not documented then it did not happen.

During an interview the DOC told Inspector #630 that the document titled

"staffing levels August 2018" was the staffing plan for the home. The DOC said that based on the staffing plan it was expected that the ratio of residents to PSW staff in each area would be eight or ten to one plus additional PSW who worked the bath shifts. The DOC said that on the evening and night shifts the ratios went down. The DOC said that they were still trying to understand how the staff were divided and assigned to residents as the system that was in place was confusing. The DOC said that in order to support the continuity of care they had staff assigned to specific areas on the PSW schedule. The DOC said that the home had been short PSW, RPN and RN staff during the summer months. The DOC said that the home had a back-up plan for situations when there was not the full complement of staff. The DOC said that they tried not to pull the bath shifts or the Behavioural Supports Ontario (BSO) shifts and that usually the decision were made by the registered staff prior to the DOC arriving in the morning. The DOC said that the registered staff would decide who was going to be pulled where with the suggestions from the Ward Clerk. The DOC said they thought that was being tracked on the staffing assignment sheet but they were not sure if this document was given to the staff working on the units. The DOC said that as they were fairly new to the home they were not very familiar with the "Staffing Plan/ Reassignment of Duties" policy and said that it was the expectation that this was followed. When asked if they used "Low Staffing Shift Routine Guidelines", the DOC said that the staff just automatically knew what needed to be done but as far as they knew this would be followed. When asked what was the process for management following-up after the back-up plan has been used on a shift to ensure that the residents' care and safety needs have been met, the DOC said that the management staff would do walk about on the floors but there was no documented record of this follow-up. The DOC said that they were not personally aware of any care or safety concerns for residents on the days when they were not fully staffed. The DOC said they did not think that he home's attendance management and performance program was actively in place in the home. The DOC said that the staff had not been able to complete the documentation of the care provided. The DOC said that they were not sure how many shifts, what days and in what areas the home was short PSW, RPN or RN hours. Inspector #630 requested that the DOC go through the schedules and tally that information in order to provide that information for the inspection.

During an interview a Ward Clerk told Inspector #630 that they were involved in scheduling staff in the home which included agency RPN staff. The Ward Clerk said they would attempt to fill vacant shifts with the home's own staff prior to contacting the agency to fill the shifts with agency staff. When asked what the

plan or process was when working short staffed, the Ward Clerk said they would try to fill with overtime. When asked if there was a policy or process on what you do when there were empty shifts that they have not been able to replace, the Ward Clerk said they were not aware of any policy or program. The Ward Clerk said they tried their best and that the home had been really short staff but it was not by fault of calling people or offering overtime but that there were just not enough people or they had worn out the staff that were available.

During an interview the interim Executive Director (ED) told Inspector #630 that they had just started in the role the day before on an interim basis. The Interim ED said that it was the expectation in the home that the staffing plan and the staffing back-up plan and policy would be followed. The interim ED said that the staffing plan was the document titled "staffing levels August 2018" was the current staffing plan and this was in place from May through to September 2018. The interim ED said that the process in the home to ensure the continuity of care was the master schedule and having lines scheduled for specific staff in specific areas of the home. When asked if prior to them starting in the home was there a method for tracking how many staff they have been short or where they were short, the interim ED said that the RCC would have conversations with the Ward Clerk but there was nothing documented. The interim ED said it was the expectation that the management in the home would know in what way on each shift the staffing plan was not being met. The interim ED said that the home has had to use the back-up plan in the past three months as they have been short shifts for PSWs, RPNs and RNs. The interim ED said that they were not aware of any care or safety concerns related to being short staffed. The interim ED said that staff had not been able to complete the required documentation of care on each shift and acknowledged that if care was not documented then it was difficult to verify if the care had been provided to the residents. The interim ED acknowledged that the home's staffing plan was evaluated in November 2017, and it was identified that an attendance management and performance program would be implemented in response to this evaluation. The interim ED said that they were not sure if this program had been fully implemented. The interim ED said that the home's job routines and duties were in the process of being reviewed and revised to ensure that the staff were organized in a way to ensure that the resident care needs were being met and that staff were clear which residents they were responsible for. The interim ED said that the home continued to make efforts to recruit more staff into vacant positions and continued to use agency RPNs to fill vacant shifts as needed. The interim ED said that the staffing plan policy indicated that all ADL's, baths, documentation,

feedings, distribution of snacks for days and evenings was expected to be completed on each shift.

Based on these observations, interviews, record and policy reviews, the licensee has failed to ensure that the home's written staffing plan for the Nursing and Personal Supports program was complied with in order to meet the care and safety needs of the residents. (630) [s. 31. (3)]

The severity of this issue was determined to be a level 2 as there was potential for actual risk. The scope of the issue was a level 2 as it was a pattern. The home had a level 3 history as they had noncompliance with this section of the LTCHA that included:
- Written Notification (WN) issued July 16, 2017 (2017_508137_0008). (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 31, 2019

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Order # / Ordre no : 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 52. (2) Every licensee of a long-term care home shall ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose. O. Reg. 79/10, s. 52 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 52 (2).

Specifically the licensee must:

a) Ensure the Pain Assessment policy is reviewed and revised with respect to communication and assessment methods for residents who are unable to communicate their pain or who are cognitively impaired as well as monitoring of residents' response to pain management strategies. This review must include a review of any tools or assessments required to be completed as part of this policy. The home must keep a documented record of this review.

b) Ensure the Director of Care (DOC), Assistant Director of Care (ADOC), all Resident Care Coordinators (RCCs), all RAI-Coordinators, all RPNs and all RNs, including agency staff, are trained on the revised Pain Assessment policy. The home must keep a documented record of the education provided.

c) Ensure the revised Pain Assessment policy is fully implemented and complied with to ensure that when a resident's pain is not relieved by initial interventions, the resident is assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A) During Stage one of the RQI Inspector #689 observed that an identified resident was showing signs of pain or discomfort.

During an interview a PSW said that they were familiar with this resident and this resident had chronic pain issues. The PSW said that the resident experienced pain when staff provided specific types of care and they would know this resident was in pain through non-verbal and verbal cues. The PSW said that some days were worse than others for the resident and there were interventions in place to help managed their pain. The PSW said that when the resident was showing signs of pain they would report this to the registered nursing staff.

The clinical record for this resident included the most recent Resident Assessment Instrument (RAI) assessment which indicated that the resident had mild pain daily. There were progress notes from the physician which identified changes in pain medication orders on specific dates. There were progress notes which stated that the resident was showing signs of pain. The electronic Medication Administration Record (eMAR) for specific time showed the resident had a documented pain rating four or greater on 25 days. There were no “CC Pain Assessment Tool” in PCC and no "Pain Management Flow Sheet" documented for the resident over a specific time period.

During an interview a RCC told Inspector #630 that they were familiar with this resident. The RCC said that this resident had known pain issues and had interventions in place to help manage the pain. The RCC said that based on the home’s current pain assessment policy they would expect that a "CC Pain Assessment" was completed when the resident was complaining of pain or the pain was not controlled. Inspector #630 and the RCC reviewed the eMAR for the resident for a specific time period and the RCC acknowledged that there were times when the resident had a pain scale greater than four. The RCC said that the PCC documentation showed that the only "CC Pain Assessments" documented was one completed twelve days prior to the interview and one completed over six months ago. The RCC said that based on the policy it would also have been expected that a "Pain Management Flow Sheet" should have been completed when the resident’s the pain was not relieved.

B) During an interview an identified resident told Inspector #630 that they had ongoing pain in specific locations. The resident said that they received pain medication to help manage their pain which included regularly scheduled medications and as needed medications. The resident said that sometimes staff

would ask them if they had pain while at other times they needed to tell the staff about their pain and ask for the medication. The resident said that they felt there had been no real improvement in their pain level since their admission to the home. The resident said they were not sure if their pain had been assessed by staff in the home.

During an interview a PSW said that they were familiar with this resident and this resident was able to tell staff when they were experiencing pain. The PSW said they thought that this resident had pain related to a specific issue.

The clinical record for this resident included the most recent Resident Assessment Instrument (RAI) assessment which indicated that the resident had moderate pain daily. There were progress notes from the physician which identified changes in pain medication orders on specific dates. There were progress notes which stated that the resident was showing signs of pain. There were progress notes which showed that the resident had a reported pain level of greater than four on four different days. There was one "CC Pain Assessment Tool" in PCC for a specific date and no "Pain Management Flow Sheet" documented for the resident over a specific time period.
During an interview a RCC told Inspector #630 that they were familiar with this identified resident. The RCC said that based on the "Pain Assessment" policy this resident would be expected to have a "CC Pain Assessment" completed any time that their pain was rated as greater than four. The RCC said that it was the expectation based on the policy that a "Pain Management Flow Sheet" was to be used when the pain medication did not relieve the pain. The RCC said they looked in the chart for this resident and could not located a completed "Pain Management Flow Sheet." The RCC said that this identified resident did have a change in their pain medication and it was the expectation that a "Pain Management Flow Sheet" would have been completed for seven days after that change.

C) During observations on specific dates Inspectors #435 and #630 observed that an identified resident was showing specific physical signs of potential pain.

During an interview a Registered Nurse (RN) told Inspector #630 that the process in the home for assessing a resident's pain involved speaking with them and using the pain scale and documenting this under vitals in PCC. The RN said that if a resident had a cognitive impairment they would go by the facial images. The RN said they were familiar with this identified resident and that this

resident did have pain at times. The RN said that they would know this resident was experiencing pain through specific non-verbal cues. When asked how long the resident had been experiencing pain the RN said that it had been on and off since admission and there had maybe been more pain in the past year. When asked what type of pain assessment was done for this resident, RN said that there would be a paper pain assessment completed but they thought this did not apply to this resident and therefor the pain would be assessed using the "PAIN AD" in PCC.

During an interview a PSW told Inspector #630 that they were familiar with this resident. The PSW said that this resident experienced a lot of pain and would have specific non-verbal cues related to the pain. The PSW said that when a resident was showing signs of pain they reported it to the registered staff to have them check the resident and provide pain medications.

The clinical record for this resident included progress notes which indicated that pain was an ongoing concern. There was a progress note for a specific date which indicated that a family member reported concerns to a staff member about this resident's pain. For specific time periods were no documented "PAIN AD" assessments in PCC Weights, no documented "Caressant Care Pain Assessment Tool" and no documented "Pain Management Flow Sheet" in the hard copy chart.

During an interview a Resident Care Coordinator (RCC) told Inspector #630 that a pain assessment was expected to be completed when a resident was complaining of pain, when pain was not well controlled or when there was a new pain medication ordered. The RCC said that there was a paper pain flow sheet as well as pain assessments in PCC using the numeric pain scale or "PAIN AD."

During a follow-up interview a RCC told Inspector #630 that they looked in the chart for this resident and could not located a documented "Pain Management Flow Sheet." Inspector #630 and the RCC reviewed the assessment section in PCC and the RCC acknowledged that there was no pain assessment documented for this resident. The RCC said it was the expectation that staff would have completed "CC Pain Assessment" and the "Pain Management Flow Sheet" for this resident as they were exhibiting behaviours that may herald the onset of pain and the pain was remaining regardless of interventions. The RCC said that this resident was unable to use the numeric pain scale and staff would be expected to use the "PAIN AD" to assess and document the resident's pain.

The RCC said that staff in the home were expected to be documenting the pain levels in PCC vital signs and acknowledged that the use of these tools were not included in the current pain assessment policy. The RCC said that based on the current policy it was the expectation that staff would be completing the completed "CC Pain Assessment" and the "Pain Management Flow Sheet" as directed in the policy. The RCC said that the staff in the home had not received education on this specific policy and they had an education session planned for later this month on documentation of pain monitoring and assessments.

Based on these observations, interviews, record reviews and policy review the licensee has failed to ensure that the home's "Pain Assessment" policy was complied with in order to ensure that when these identified residents' pain were not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (630) [s. 52. (2)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm. The scope of the issue was a level 3 as it affected 3 out of 3 residents reviewed. The home had a level 2 compliance history as they had no history of non-compliance with this section of the legislation. (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 31, 2018

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e) 151, rue Bloor Ouest, 9e étage Toronto ON M5S 2T5	Directeur a/s du coordonnateur/de la coordonnatrice en matière d'appels Direction de l'inspection des foyers de soins de longue durée Ministère de la Santé et des Soins de longue durée 1075, rue Bay, 11e étage Toronto ON M5S 2B1 Télécopieur : 416 327-7603

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

Issued on this 23rd day of October, 2018

Signature of Inspector /
Signature de l'inspecteur :

Ontario

Ministry of Health and Long-Term Care

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

Ministére de la Santé et des Soins de longue durée

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

Name of Inspector / Nom de l'inspecteur : Amie Gibbs-Ward

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