Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

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

Rapport d'inspection en vertu de la Loi de 2007 sur les foyers de soins de longue durée

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

London Service Area Office
130 Dufferin Avenue 4th floor
LONDON ON N6A 5R2
Telephone: (519) 873-1200
Facsimile: (519) 873-1300

Bureau régional de services de London
130, avenue Dufferin 4ème étage
LONDON ON N6A 5R2
Téléphone: (519) 873-1200
Télécopieur: (519) 873-1300

Amended Public Copy/Copie modifiée du rapport public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Dec 23, 2019	2019_722630_0005 (A3)	029560-18, 029562-18, 029563-18, 029564-18, 029566-18, 029567-18	Follow up

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

Amended by MELANIE NORTHEY (563) - (A3)

Amended Inspection Summary/Résumé de l'inspection modifié

On December 19, 2019, a request for an extension of the compliance due date of January 15, 2020, for Compliance Order #002 issued in inspection #2019_722630_0005, was received from Kim Leuszler, Chief Operating Officer for Caressant Care. The new compliance due date requested was February 15, 2020. After a teleconference on December 23, 2019 with home management staff, OMNI staff, LSAO Inspection Managers and Inspectors an extension was agreed upon with a new compliance due date of February 15, 2020.

Issued on this 23rd day of December, 2019 (A3)

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

Original report signed by the inspector.

Ontario

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Amended by MELANIE NORTHEY (563) - (A3)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): February 25, 26, 28, March 1, 4, 5, 6, 7, 8, 11, 12, 13, 14 and 18, 2019.

The following Follow-up intakes were completed within this inspection related to Compliance Orders (CO) from Resident Quality Inspection #2018_722630_0019:

Follow-up Log #029560-18 for CO #001 related to compliance with the plan of care;

Follow-up Log #029562-18 for CO #003 related to repositioning of residents who are dependent on staff for care;

Follow-up Log #029563-18 for CO #004 related to housekeeping procedures in the home;

Follow-up Log #029563-18 for CO #005 related to maintenance procedures in the home;

Follow-up Log #029566-18 for CO #007 related to the written staffing plan for nursing and personal care services;

Follow-up Log #029567-18 for CO #008 related to pain assessments.

Documentation of non-compliance related to Critical Incident Inspection #2019_722630_0006 for Log #026289-18 and Log #005210-19 have been documented within this Follow-Up Inspection Report.

Documentation of non-compliance related to Complaint Inspection #2019_722630_0007 for Log #001230-19 and Log #005055-19 have been documented within this Follow-Up Inspection Report.

During the course of the inspection, the inspector(s) spoke with the Caressant

Care Director of Operations, the Caressant Care Regional Director, the Caressant Care Regional Director Operations, the Caressant Care Director of Clinical Services and Education, the Caressant Care Director of Quality and Privacy, Caressant Care Corporate Environmental Services Consultant, Sienna Senior Living Vice President Operations, Sienna Senior Living Director of Operational Effectiveness, the Executive Director (ED), the Director of Care (DOC), the Assistant Director of Care (ADOC), a Resident Care Coordinator (RCC), Resident Assessment Instrument (RAI) Co-ordinators, the Environmental Services Supervisor (ESS), the Nutrition Manager, the Registered Dietitian (RD), a Physiotherapist (PT), a Ward Clerk, the Behavioural Supports Ontario (BSO) Registered Practical Nurse (RPN), the BSO Personal Support Workers (PSW), Registered Nurses (RN), RPNs, agency RPNs, PSWs, Housekeepers, Laundry Aides (Guest Attendants), Maintenance staff, Dietary Aides (DA), family members and residents.

The inspectors also observed resident rooms and common areas, 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 various meeting minutes, reviewed written records of program evaluations, reviewed recommendations provided to the home by Sienna Seniors Living, and also reviewed the Caressant Care Woodstock Plan of Corrective Action.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Laundry
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Pain
Personal Support Services
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.
- **10 WN(s)**
- **2 VPC(s)**
- **8 CO(s)**
- **1 DR(s)**
- **0 WAO(s)**

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
O.Reg 79/10 s. 50. (2)	CO #003	2018_722630_0019	563
O.Reg 79/10 s. 90. (1)	CO #005	2018_722630_0019	563

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

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

Specifically failed to comply with the following:

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 :

The licensee has failed to comply with Compliance Order (CO) #001 from #2018_722630_0019 issued on October 23, 2018 with a compliance due date of December 31, 2018.

The licensee was ordered to ensure that they were compliant with s 6. (7) of the LTCHA.

Specifically the licensee was ordered to:

a) Ensure that the care set out in the plan of care related to mobility and falls prevention was provided to the resident as specified in their plan.
b) Ensure that a monitoring process was 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 was to be documented.

The home failed to complete steps a) and b).

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date which reported that an identified resident had fallen.

During interviews with specific staff members they said that this identified resident had a specific intervention in place for falls prevention.

A review of the current care plan for this resident showed it included this specific intervention as part of falls prevention.

During the inspection, Inspector #730 observed on multiple occasions that this resident did not have this specific intervention in place.

In an interview with a Resident Care Coordinator (RCC) and the Assistant Director of Care (ADOC) they indicated they were familiar with CO #001 from Inspection #2018_722630_0019. The RCC stated that it was their expectation that this interventions would have been in place for this resident related to their falls prevention plan of care. When asked how the home complied the order to ensure that the care set out in the plan of care related to mobility and falls prevention was provided to the resident as specified in their plan, the RCC said the interventions should be on Point of Care (POC) for tasks for the staff as well as on the kardex and the care plan and this was not a change of practice. The RCC said they thought the RAI Coordinators would have documentation as they were to ensure that the documentation of care was completed. The ADOC said they were auditing regularly and doing weekly walkabouts to identify individuals with high risk factors for falls. The ADOC said they would check one resident room each week to make sure all the interventions were in place. When asked if they would provide documentation to support the audits and walkabouts, the

ADOC said they thought someone else had provided Inspector #730 with this information and did not have any documentation to provide.

In an interview a Resident Assessment Instrument (RAI) Coordinator said they had been involved in working on complying CO #001 regarding mobility and falls preventions and it was an ongoing process. RAI Coordinator said their role was to ensure the plan of care had been updated with interventions. When asked if they were part of ensuring that staff are providing care as per the care plan regarding falls prevention and management, they said they thought that was the Resident Care Coordinators (RCCs) who dealt with that.

In an interview the Caressant Care Director of Operations (DOO) told Inspector #630 that they were not able to find documented evidence that management staff in the home had been doing regular audits of the care provided to residents in the home and could provide no documented audits or walkabouts completed for February 2019.

In an interview the Director of Operations (DOO) told Inspector #730 that the process that had been developed to monitor the falls prevention care was that one of the Resident Care Coordinators (RCCs) would use the risk management tool to make sure the resident had what they needed and would be out on the floor checking. The DOO said they were not sure how the process had been implemented that there was no plan fully implemented within the home to ensure that the plan of care for residents at moderate or high risk for was falls were being provided to the residents as specified in the plan. The DOO said that it did not look like there was any tool developed for that purpose within the home.

The licensee has failed to ensure that the care set out in the plan of care was provided to this identified resident for falls prevention, as specified in the plan. The licensee also failed to comply with Compliance Order (CO) #001 from #2018_722630_0019 issued on October 23, 2018, as they did not develop and fully implement a documented monitoring process, to ensure that the plan of care for residents at moderate or high risk for falls were being provided to the residents as specified in their plan. (730) [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 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 :

The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A Written Notification (WN) and Compliance Order (CO) #005 was issued October 23, 2018 during the Resident Quality Inspection (RQI) #2018_722630_0019 with a compliance due date of December 31, 2018. The home was ordered to be compliant with O.Reg. 79/10 s. 90.(1)(b) as part of the organized program of maintenance services under clause 15 (1) (c) of the Act.
Specifically the licensee was ordered to:

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."

The home was compliant with Ontario Regulation 79/10, s. 90 (1)(b) as they completed part a), b), c) and d). The home failed to complete part e) to ensure the home, furnishings and equipment were kept in good repair.

The home areas were observed for disrepair and Inspector #563 identified the following:

Level One and Two - A Side:
- Room A139 six of six armchairs legs remained scuffed,
- Room A239 four of four armchairs legs remained scuffed,
- Multiple flooring tiles lifted and peeling, chipped at the corners and broken, and
- Tub Room A247 had multiple missing wall tiles near the toilet and bathtub along the wall perimeter and the corner wall near the baseboard behind the tub room door had two chipped tiles.
- Flooring throughout was lifting and peeling and the corners were cracked in areas, as well in the stairwells.

Level One - B Side Hallway:
- Floor tiles chipped in multiple areas leading towards the North, South and East wings, and
- Baseboard was still missing and not replaced or repaired in the hallway at the East wing intersection.

Resident Rooms - Level One B Side:
- Multiple corner plastic covers on doorframes peeled off, cracked or chipped.
- Multiple baseboards and the corner walls had chipped paint and exposed glue and brick.
- Multiple resident bathrooms had chipped paint, the caulking around sinks were cracked and peeling with white hard build-up of residue on faucets and taps, faucets were chipped and peeling, cupboards were chipped along the lower edge

and baseboards were peeling with wall disrepair and stained flooring.
- Multiple resident door frames were chipped with dried paint splatter on the floor, baseboards peeled in resident rooms and walls had noted areas of disrepair.
- Baseboards chipped and peeling at corner edge of doorframes with dried paint on top of old dust and dirt on the floor.
- Missing baseboard on either side of the hall and where the baseboard was pulled away from the floor had a build-up of dust, hair and debris.
- Floor tiles indented with cracks and build-up of dust and dirt, door frame had a build-up of dirt and dust at the corners.

Inspector #630 interviewed a resident who reported they had damaged walls in their private room. The resident pointed to an area by the bathroom door and on the wall across from the bathroom and stated the disrepair had been there a long time. The resident stated the room needed the drywall fixed and a coat of paint. The resident also reported concerns of disrepair in their bathroom. Inspector #630 observed an area of wall damage beside the bathroom with a hole in the wall near the floor approximately 10 cm in length. As well there was a damaged area about one meter in length near the floor on the wall across from the bathroom with paint and drywall scraped.

The Caressant Care Director of Operations (DOO) explained that they completed a "Monthly Housekeeping Audit" and that the documentation identified areas that required cleaning, painting, repairs or replacement in all resident rooms in the home.

The Woodstock Nursing Home (NH) Environment Audit for Level One B identified the following:
- 19 washroom floors needed replaced, all rooms required strip and wax
- 16 washroom walls needed painted
- 21 sinks and fixture faucets needed replaced
- 5 sinks needed to be caulked
- 6 toilets needed to be replaced
- 23 toilets needed caulking

The Woodstock NH Environment Audit for Level One and Two A Side completed November 8 & 9, 2018, identified the following:
- all washroom floors needed strip and waxed
- all registers need to be painted
- all chair legs needed stained and varnished

- 11 room floors needed repaired and five to be replaced and two washroom floors to be replaced
- 33 rooms needed painted, 60 door frames and handles needed to be painted and 12 washroom walls to be painted
- four stained tiles to be replaced
- eight chipped vanities for repair
- four fixtures to be replaced
- 24 toilets required caulking

The Caressant Care Director of Operations (DOO) stated that the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form did not include monitoring to ensure that the home, furnishings and equipment were kept in good repair. The furnishings were not a part of the monitoring by the Environmental Services Supervisor (ESS) weekly. The DOO shared that the Woodstock Nursing Home (NH) Environment Audit was a summary of the results from the initial audits of resident rooms and common areas completed in November 2018. The findings were then entered into the online Maintenance Care (MC) system to monitor completion. The DOO produced a "Detail Report" from MC that cataloged routine daily, weekly, monthly, quarterly, annual and preventative maintenance tasks. The "Bathroom Renovations" schedule was reviewed and the DOO verified that 17 of 29 bathrooms on Level One B Side, North, South and East wing were completed.

The Caressant Care Woodstock Plan of Corrective Action for Inspection 2018_722630_019 documented that the Environmental Service Supervisor (ESS) was to develop a weekly monitoring process and fully implement to ensure that the homes furnishings and equipment were kept in good repair.

The "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form documented "Common Areas"; "Resident Rooms"; and "Safety." This weekly checklist did not include monitoring to ensure that the home, furnishings and equipment were kept in good repair.

The Caressant Care Nursing & Retirement Homes Ltd. audit titled "Caressant Care Preventative Maintenance Program Resident's Rooms/Common Areas Quality Improvement Action Plan" last completed December 2018, documented specific items to be addressed in resident's rooms in each wing, but there was no documented inspection of common areas.

The Caressant Care (CC) Corporate Environmental Services Consultant (CESC) stated their role was to oversee all aspects of environmental services, primarily maintenance and housekeeping, as well as policy implementation and corporate contracts. The CESC said the daily running of the home was the responsibility of the ESS and Executive Director (ED). The CESC stated that a task list report was created from Maintenance Care to verify the completion and status of repairs daily, and the report was also used to prioritize the work daily. The CESC also stated that MC also tracked their ongoing routine preventative maintenance tasks which were automatically generated for completion. The CESC verified that the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form did not include monitoring to ensure that the home was clean and repaired and it was more of a safety check. The CESC stated that a complete bathroom refurbishing was being completed for all of Level One B Side, a full time painter was hired and the home was currently reviewing flooring costs for the entire home because the tiles were starting to crack and lift; and these interventions were being implemented to ensure areas of disrepair were being addressed. The CESC said the "Caressant Care Preventative Maintenance Program Resident's Rooms/Common Areas Quality Improvement Action Plan" was verified completed in December 2018, but the CESC stated some repair items were put on hold when the decision was made to replace the vanities and floors during the remodel of the Level One B Side bathrooms.

The Environmental Services Supervisor (ESS) stated they had worked for Caressant Care Woodstock since December 2018, as the designated lead for the housekeeping, laundry and maintenance service programs. The ESS explained the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form was used to monitor and document common areas, resident rooms and safety concerns in the home. The ESS verified this checklist did not satisfy a weekly monitoring process developed and fully implemented to ensure that the home, furnishings and equipment were kept in good repair. The ESS also verified that although the checklist identified "Environmental Services/Maintenance person ", the form did not include the staff responsible for monitoring. Other management staff members, including Sienna, also completed this checklist without identifying the staff member responsible for the monitoring each week it was completed. The ESS was asked how the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form satisfied CO #005 where the home was to ensure a weekly monitoring process was developed and implemented, including the staff responsible for monitoring, to ensure that the home was clean and repaired and the ESS replied that it did not, but the weekly housekeeping audit

was developed to comply this. The ESS verified that the “Weekly Housekeeping Audit” did not include home areas of disrepair; only resident rooms had been monitored weekly. Inspector #563 and the ESS discussed the areas of disrepair observed in the home and the ESS stated that a total renovation was underway for all Level One B Side bathrooms. Each resident bathroom was planned to have a new toilet, new sink, new vanity, new flooring or repairs, wall repairs, new baseboards and a contracted painter was on site. The renovations and painting schedule was built into the online Maintenance Care schedules for routine, preventive and remedial maintenance.

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 the home and furnishings were maintained in good state of repair. The licensee also failed to comply with part e) of Compliance Order #005 from Inspection #2018_722630_0019, as the weekly monitoring process was not developed and fully implemented, including the staff responsible for monitoring, to ensure that the home, furnishings and equipment were kept in good repair. (563) [s. 15. (2) (c)]

Additional Required Actions:

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

(A3)
The following order(s) have been amended / Le/les ordre(s) suivant(s) ont été modifiés: CO# 002

WN #3: 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 :

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.

A) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10 s. 49 (2) states "Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls."

The home submitted a Critical System Incident (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), on a specific date regarding a fall for an identified resident.

An incident progress note for this identified resident included details of the fall and stated that "a head injury routine (HIR) was initiated."

The home's policy titled "Safety Plan - Resident" with a reviewed date of May 2018, stated under section "Part C - Post Fall Management" "a) Initiate Head Injury Routine and assess the resident's level of consciousness and any potential injury associated with the fall as required."

During an interview a registered nursing staff said that after a resident had fallen the staff were expected to assess the resident and to do a head to toe, take vital signs, assess any injury for transfer to hospital and do a HIR for 72 hours if the fall

was unwitnessed or if the resident hit their head. The staff member said they were not able to locate the HIR form in this resident's paper chart.

Inspector #730 reviewed paper chart for this resident and was unable to locate the HIR form.

During an interview a Resident Care Coordinator said that the Head Injury Routine (HIR) was part of the home falls prevention and management policy. The RCC said that if a fall was unwitnessed then the staff were to do this or if it is witnessed and they hit their head the staff would need to complete.

During an interview the Director of Care (DOC) stated that they were not able to locate the HIR form for this resident. The DOC stated that it appeared that a HIR had been initiated per the progress notes for this resident, but they were not able to locate the documentation. When asked if it was in policy that a head injury routine would be completed for this fall, the DOC replied yes.

The licensee has failed to ensure that any actions taken with respect to a resident under the falls prevention and management program, including assessments, were documented. (730)

B) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

Ontario Regulation 79/10 s. 50 (2) (d) states "Every licensee of a long-term care home shall ensure that 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."

Written Notification (WN) and Compliance Order (CO) #003 was issued October 23, 2018 during the Resident Quality Inspection (RQI) #2018_722630_0019 with a compliance due date of December 31, 2018. The licensee was ordered to comply with Ontario Regulation 79/10 s. 50 (2) (d). Specifically the licensee was order to ensure that: "a) Ensure that resident #006 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."

Based on observations and interviews the home was compliant with Ontario Regulation s.50 (2) (d) and completed step a) of CO #003. The licensee failed to complete step b).

Residents' clinical records were reviewed by Inspector #563 related to care skin care requirements for turning and repositioning every two hours. Based on this review seven residents were identified as needing to be repositioned by staff. The clinical record review showed all seven resident were at risk for skin breakdown and all seven residents did not have the turning and repositioning task in Point Click Care for documentation prior to March 2019.

The Resident Care Coordinator (RCC) stated the Point of Care (POC) task for turning and repositioning was removed for all residents and the nursing team was now putting it back into POC for only those residents that required it. The RCC stated the Resident Assessment Instrument Coordinator (RAI-C) reviewed the kardex for all residents and for those residents who were limited, extensive or total assistance for bed mobility were care planned for turning and repositioning. The RCC stated that there should have been a POC task for all residents that required turning and repositioning. POC was the documentation system in place for the PSWs and the RCC shared there was no documentation in POC because there was no task in POC for the PSWs to document the turning and repositioning for those residents dependent of staff.

The Resident Instrument Assessment Coordinator (RAI-C) stated there was a management meeting to go over the findings from the RQI report and it was Sienna's recommendation to only have the turning and repositioning as part of the resident's care plan and kardex. The RAI-C was asked if the documentation of the repositioning care provided by staff was completed for all residents who were dependent on staff for repositioning and the RAI-C stated they were in the process of adding the turning and repositioning as a task for documentation in Point of Care for the PSWs.

The seven residents were observed by Inspector #563 and were turned and

repositioned every two hours or more. Personal Support Workers provided assistance for transfers to and from bed, with toileting routines and with bed mobility. The residents were dependent on staff for repositioning and were repositioned every two hours or more.

The Registered Nurse (RN) and Skin and Wound Lead stated that it was the responsibility of the RAI Coordinators for adding and removing tasks in POC for a resident. The Skin and Wound Lead also shared that management had a meeting and the decision was to take the repositioning task out of POC. The repositioning task was only to be in the kardex and care plan and not added to any resident in POC for PSW documentation. The Skin and Wound Lead stated that the seven residents required staff participation for bed mobility with turning and repositioning every two hours and would not have had accurate and complete documentation of the repositioning care provided by staff before March 2019.

The Sienna Senior Living Director of Operational Effectiveness (DOOE) stated that PSWs were required to document turning and repositioning in POC. The SSL DOOE was asked if they were aware that the POC task for turning and repositioning was removed from POC in December 2018 and they replied “no”. Inspector #563 shared that the turning and repositioning task had only recently been added again for those residents who required turning and repositioning and the SSL DOOE stated they were not aware as there was a plan of action that it was to be done by the end of December to accurately reflect each residents needs as assessed.

Based on observations, staff interviews and review of clinical records, the licensee failed to ensure that any actions taken with respect to a resident under the Skin and Wound Program, the resident’s responses to interventions were documented. The licensee also failed to comply with components of CO#003 from Inspection #2018_722630_0018, specifically related to the accurate and complete documentation of the repositioning care provided by staff to any resident who was dependent on staff for repositioning which had a compliance due date of December 31, 2018. (563) [s. 30. (2)]

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. 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 :

The licensee has failed to ensure the written staffing plan required for the organized program of nursing services and the organized program of personal support services under clause 8 (1) (b) of the Act, provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The licensee has failed to comply with Compliance Order (CO) #007 from Inspection 2018_722630_0019 served on October 23, 2018, with a compliance date of January 31, 2019.

The licensee was ordered to ensure that they were compliant with O.Reg 79/10 s

31. (3).

Specifically the licensee was ordered to:

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 backup 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.

The licensee completed step a).

The licensee failed to complete all components included in steps b), c), d) and e).

A) The Ministry of Health and Long-Term Care (MOHLTC) received complaint log #005055-19 which identified concerns with staffing and the care provided to their family member in the home.

During an interview with a family member for an identified resident they expressed concerns that they felt there was insufficient staffing in the home. The family member expressed specific concerns with the care provided to an identified resident.

The plan of care for this identified resident included specific interventions.

During the inspection, Inspector #630 observed that this identified resident was in a specific position at specific times which differed from the plan of care.

During an interview a staff member said that they would know what care a resident required from the kardex and through word of mouth. The staff member said that there were times when there were only two PSWs working in a specific area of the home and there was at times delayed response time to calbells and care requests. The staff member said at least three quarters of the residents in their area required a mechanical lift or sit to stand lift with two staff for transfers.

During an interview another staff member said they would look in the kardex to know what care a resident required. The staff member said it was difficult at times to provide the residents with the care they required. The staff member said they felt the staffing levels in the home were affecting care such as answering callbells in a timely way, toileting care, laying resident down and mouth care.

During an interview the Assistant Director of Care (ADOC) said that staff would know residents' care needs from the kardex and plan of care. The ADOC reviewed the plan of care and kardex for this resident and said that they needed specific care from staff. When asked if the staff in the home were able to provide this type of care consistently to residents, the ADOC said that residents had to wait at times as there were a lot of residents who required assistance.

B) During the inspection, Inspector #630 observed that an identified resident had activated their callbell related to needing continence care from staff. Based on this observation the resident waited at least nine minutes for continence care from staff.

During an interview this identified resident said they required assistance from staff with continence care and toileting. This resident said that they thought that usually the staff responded in a timely manner but sometimes they had to wait longer as the staff were busy.

During an interview a staff member said the expectation in the home was for staff to answer the callbells as fast as they could. The staff member said there were times when they did not have full complement of staff or staff were on breaks when there were only two PSW staff for their area of the home and at those times residents had to wait for assistance from staff. The staff member said this identified resident required assistance from staff with continence care.

During an interview the Assistant Director of Care (ADOC) said it was the

expectation that staff would respond to the callbells as soon as possible. When asked if they had identified any concerns with residents not receiving the continence care they required in the home, the ADOC said there had been some issues. The ADOC said if the PSWs were busy with one resident and then there was another callbell activated it could take 10 to 15 minutes to give care and would then be a delay in the response to the other resident. The ADOC said there had been times when they had to help with continence care and had called the registered staff to help with the toileting needs.

C) During an interview a registered nursing staff member told Inspector #689 that the expectation in the home was that a pain assessment would be completed when providing an as needed medication for pain to a resident. The registered nursing staff member said that they had received education on the pain assessment policy and found that they did not have enough time to do it all.

During the inspection, Inspector #630 observed that the callbell for another identified resident was activated and there were no staff in that area at the time. Based on this observation this resident waited at least 20 minutes for assistance from staff related to reported pain.

During an interview a registered nursing staff member told Inspector #689 that this resident had specific care concerns related to pain. They said this resident had reported pain on this specific shift.

Based on review of the clinical record by Inspector #689 there was no documented evidence that a pain assessment or pain monitoring was completed for this resident on the this specific shift.

During an interview a staff member said that it was challenging in that area to meet the care needs of the residents even when they were fully staffed and especially if they did not have all five PSWs available. The staff member said that due to the care needs of the residents in that area related to responsive behaviours as well as the number requiring total care from staff. The staff member said that the staff felt overwhelmed and at times they would go home after their shift feeling badly and concerned they did not do enough for the residents. The staff member said that sometimes during peak hours for care, such as after meals, residents were having to wait 15 minutes for care from staff.

D) During the inspection, Inspector #630 observed that the callbell for resident

another identified resident was activated. Based on this observation this resident waited at least 18 minutes for continence care from staff.

During the inspection on another day, Inspector #630 observed that there were three callbells activated in one area, including the one for this identified resident's room. Based on this observation this resident waited at least seven minutes for continence care from staff.

During the inspection on another day, Inspector #630 observed that the callbell for this resident's room was activated as well as for two other rooms in the area. Based on this observation this resident waited at least 15 minutes for continence care from staff.

The plan of care for this resident indicated that they required specific type of care from staff.

The staff member said they would know what care a resident required by the kardex and from knowing the residents in the home. The staff member said they were familiar with this identified resident. The staff member said that the staff were not always able to provide this resident with continence care in a timely as they were providing care to other residents in the area.

E) During the inspection, Inspector #630 arrived in a specific area and it was observed that the callbell for an identified resident was activated and there were no staff in the hallway. Based on this observation this resident waited at least 32 minutes for care from staff.

During an interview this resident told Inspector #563 that they had rung the bell for assistance with toileting care and were waiting for assistance from staff. This resident said that they would have to wait for assistance with the bathroom and that they thought there were times when they had to wait over an hour for assistance. This resident said that there were times when staff did not assist them in time to prevent incontinence. This resident said they had no other concerns about the home other than they did not seem to have enough staff.

The plan of care for this resident included specific care interventions they required from staff for continence care.

During an interview a staff member told Inspector #630 that they would know what

care residents required with continence care and toileting from the plan of care and from knowing the residents. When asked if residents had been receiving the assistance with toileting and continence care that they require in the home, the staff member said to the best that the staff were able but they needed more staff as residents were sometimes having to wait for care. When asked what the expectation was in the home in regards to responding to callbells, the staff member said they thought it was two minutes but sometimes they were with another resident and then another one was requesting assistance and they could not leave one unattended and sometimes that took time but they tried their best. The staff member said this resident required specific types of care from staff for continence care.

On another day during the inspection, Inspector #630 observed that the callbell for this identified resident was activated. The resident told Inspector #630 that they had rang their callbell and were waiting for assistance from staff to use the toilet. Based on this observation this resident waited at least 18 minutes for continence care from staff.

On another day during the inspection, Inspector #630 observed that the callbell for this resident was activated. Based on this observation this resident waited at least 18 minutes for continence care from staff.

F) During the inspection, Inspector #630 observed that the callbell for another identified resident was activated and there were no staff in the area as they were in other residents' rooms. Based on this observation this resident waited at least 21 minutes for care from staff.

During the inspection, Inspector #563 observed that the callbell for another identified resident was activated. Based on this observation, this identified resident waited at least 22 minutes for care from staff.

During an interview a staff member told Inspector #563 that on in that area there were only three PSWs to do everything on the day shift and that was not enough. The staff member said that the staff tried their best to give good care but there was not enough staff.

G) During the inspection, Inspector #630 arrived in a specific area and observed that an identified resident was in a specific position and had spilled a beverage on their lap and the floor. Based on this observation this resident waited at least 41

minutes for the care they required from staff.

During an interview a Resident Care Coordinator (RCC) told Inspector #630 that they were familiar with this resident and they were considered to be at risk for falls. The RCC said that this resident required specific assistance from staff.

The plan of care for this resident included specific interventions.

During the inspection Inspector #630 observed this identified resident in a specific position. During this observation the resident was provided a beverage by a staff member and the resident was observed to spill the beverage on their lap and the floor. Based on this observation this resident waited at least 27 minutes for the care they required from staff.

During an interview this staff member said they were familiar with this resident and they required specific care from staff. The staff member said staff tried their best to provide the care that this resident required. The staff member said that even when they were fully staffed with PSWs it was difficult to provide the residents with the care they required.

H) During the inspection, Inspector #630 observed another identified resident in their room verbally requesting staff assistance to use the washroom. A staff member went into the room and asked the resident to wait a few minutes as someone would be coming. Based on this observation this resident waited at least 15 minutes for continence care from staff.

During the inspection on another day, Inspector #630 observed this identified resident in their room with the callbell activated. Based on this observation this resident waited at least 23 minutes for continence care from staff.

The plan of care for this resident included specific interventions related to continence care.

During an interview with a staff member they said they were familiar with this identified resident and they required specific assistance from staff with continence care. This staff member said that sometimes this resident had to wait for assistance with toileting.

I) During the inspection, another identified resident's callbell was activated and

the resident was yelling. A staff member was observed going to speak with the resident at a specific time and the resident asked them for a specific type of assistance and the staff member said they would get someone to help them. Based on this observation this resident waited at least 40 minutes for positioning and responsive behaviour care from staff.

The plan of care for this resident included specific interventions related to positioning and responsive behaviours.

J) During the inspection, Inspector #630 observed that the posted breakfast time in the Level One B Side dining room was 0800 hours. It was observed that staff and residents were still arriving in the dining room over 30 minutes after the posted breakfast time.

During the inspection, Inspector #630 observed that the posted lunch time for Level Two A Side was 1200 hours and there were no PSWs in the dining room to assist residents and 11 empty set spots at the tables. It was observed that staff and residents were still arriving in the dining room over 20 minutes after the posted breakfast time.

During an interview a staff member said that the breakfast meal was scheduled to start at 0800 hours. When asked if staff were consistently able to have residents ready for the breakfast meal by 0800 in the morning, the staff member said that not in that area and usually residents and staff were getting there around 0830 hours. The staff member said that because of the care that they had to give residents each morning with dressing and toileting and cleaning and most of the residents required assistance from two staff it was difficult to get to the dining room in time.

During an interview the Nutrition Manager (NM) said the scheduled mealtimes in the home were 0800, 1200 and 1700 hours. When asked if staff were consistently able to have residents ready for the meals to be served at the scheduled times, the NM said no and they tried to be flexible with the meal service. NM #158 said that sometimes breakfast was not served until 0830 hours. The NM said this had an impact on the residents as it affected the amount of time that they had to eat their meals and they were more rushed and they could only hold the food for service for so long. The NM said that the PSWs were the ones bringing the residents into the dining room for the most part and a lot of times the staff were late.

K) During an interview a registered nursing staff member told Inspector #630 that the home had still been experiencing multiple shifts when they were working either part of full shifts without a full complement of staff. The staff member said that the home tended to use agency Registered Practical Nurses (RPNs) regularly. The staff member said that there were times when it was not possible for staff to get to residents as quickly or in a timely fashion.

During an interview with another registered staff member, they said that the Registered Nurses (RNs) in the home were responsible to ensure the residents were safe and stable, ensure medications done correctly, follow proper procedures, communicating changes of condition with the physicians and being in-charge of the floor and working as a team. The staff member said that after a resident had a fall they were responsible for assessing the resident and providing any required care. The staff member said that there were times when they did not have time during their shift to do all the documentation that was required related to falls assessment and they would stay after their shift to complete the documentation. The staff member said that they stayed after their shift on a regular basis. The staff member said there was a specific shift that they did not have time to complete the documentation for a post-fall assessment. The staff member said they tried their best to prioritize the care provided and to meet the needs of the residents but it was difficult especially when they were the only registered staff in the building on some night shifts.

During an interview a Resident Care Coordinator (RCC) reviewed the progress notes and acknowledged that there was no documentation of a post-fall assessment as per the expectation in the home for a specific resident on a specific shift. The RCC said they were not sure if this staffing issue had been discussed at the daily management meeting huddle.

L) During an interview the Executive Director (ED) told Inspector #630 that they had started working in the home in the ED position in January 2019. The ED said they were familiar with the CO #007 from Inspection #2018_722630_0019 and that the previous leadership in the home had been involved in working to comply the orders. The ED said that they had not personally been involved in reviewing the staffing plan as this had been done by the former Director of Care (DOC). The ED said that from their understanding the only change that was made to the staffing plan was the timing of shifts for the registered nursing staff. The ED said the leadership team in the home had been monitoring the shifts where there was

not a full complement of staff working in the home and thought there had been improvements. When asked about the process for monitoring whether the staffing plan was meeting the care and safety needs of the residents, the ED said that point of care was monitored by the RAI Coordinators to ensure documentation was completed and the management all discussed staff shortages at the daily meetings.

During an interview a Resident Care Coordinator (RCC) said they were familiar with the CO #007 from Inspection #2018_722630_0019. The RCC said that the staffing plan in the home was the “Daily Staff Assignment” sheet in combination with the “Routine Staffing Plan.” The RCC said they were not personally involved in the review of the staffing plan. The RCC said that they thought that the former DOC had reviewed the plan but they could not find a documented record of this review. The RCC said that there were changes made to the staffing back-up plan but there were no changes made to the routine staffing plan in the home.

During an interview the Caressant Care Director of Operations (DOO) told Inspector #630 that they had been the interim Executive Director (ED) in the home from September 2018 until the new ED was hired in January 2019. The DOO said they were familiar with the CO #007 from Inspection #2018_722630_0019. The DOO said that the staffing plan in the home was the “Daily Staff Assignment” sheet in combination with the “Routine Staffing Plan.” The DOO said they were not personally involved in the evaluation of the staffing plan and that the former DOC and Caressant Care Director of Quality and Privacy (DOQP) had been involved. When asked what was done to assess the residents care and safety needs to determine if the staffing plan was meeting those needs, the DOO said that they knew they had enough staffing with the staffing lines and the issue had been absenteeism. The DOO said they also did this through completing resident care audits. When asked to provide documented evidence of the resident care audits, the DOO said they were unable to locate documentation of the care audits. The DOO said that they had developed a process in the home to monitor and evaluate the staffing in the home as part of the “daily risk and leadership team huddle” and acknowledged that the form that had been developed had not been fully implemented. The DOO said that there were no changes made to the staffing plan as the RCC had done some work on changing the staffing lines and the staff routines for PSW but that had been stopped by the union in the home and was not implemented. When asked what was used to determine if the number of staff in each area of the home was meeting the care needs of the residents, the DOO said they thought that they looked at the Case

Mix Index (CMI) but could not provide documented evidence that this had been included as part of the review. The DOO said they had provided a copy of the revised staffing back-up plan as a printed copy to all staff but they did not have documented evidence to show that all staff reviewed this plan. The DOO said there had been an improvement in the staffing levels in the homes in terms of vacant shifts. The DOO said that there had been a small increase in the use of agency RPNs in the home as the home was having trouble recruiting and they tried to get the same agency staff consistently.

The Caressant Care Director of Operations (DOO) provided Inspector #630 with the "Quality Program Evaluation Nursing and PSW Staffing Plan" dated October 30, 2018. This form did not include any trends or noted changes related to resident care or safety needs of staffing levels in each area of the home. This form also did not include any documented evidence that the staffing plan had been reviewed and revised to ensure it was meeting the care and safety needs of residents.

During an interview, the Sienna Senior Living Director of Operational Effectiveness (SSL DOE) told Inspector #630 that they were familiar with the CO #007 from Inspection #2018_722630_0019. The SSL DOE said that they were not personally involved in evaluating the staffing plan as that had been the Sienna Seniors Living Vice President of Operations. The SSL DOE said that they had provided samples of staffing plans and education to the past Executive Directors in the home on how to develop staffing plans and contingency plans. When asked if they had been involved in monitoring whether the staffing plan was meeting the care and safety needs of the residents, the SSL DOE said that they had conversations with the management in the home about the care of residents during the management team meetings. The SSL DOE said that the staffing issues and variances in staffing levels was being discussed at the daily management meetings but was not sure if this was being documented in the home. The SSL DOE said the home did not have a way to monitor staff response to the callbells and the only way to do this was to watch and monitor and they were not sure if anyone in the home was monitoring this. When asked if they had identified any areas of care not being provided to residents based on their review of care in the home, the SSL DOE said they could not say specifically about care to residents but the documentation did not always meet the expectations and they had told the staff that assessments that were done but not documented then there was no way to prove that it was done. The SSL DOE said they had identified that there was documentation of pain assessments, skin and wound assessments and

post fall assessments that had not been completed as per the expectations in the home. The SSL DOE said they thought that the staffing plan for the mix of registered staff was not a contributing factor to assessments not being completed and instead it was about holding staff accountable, ensuring staff were compliant and reviewing and revising things like staffing routine and the schedules for medication administration.

During a telephone interview the Sienna Seniors Living Vice President Operations (SSL VPO) told Inspector #630 that they were familiar with the CO #007 from Inspection #2018_722630_0019. The SSL VPO said that they had been involved in a collaborative effort to review the written staffing plan with the Sienna Seniors Living Director of Operational Effectiveness (DOE) and the Caressant Care Director of Operations (DOO) as well as the management working in the home. The SSL VPO said they initiated the process and they were involved in reviewing and evaluating the staffing plan but were unable to provide the specific date that they were involved. The SSL VPO said there were no changes made to the staffing plan as there was no need for changes. When asked how it was determined that no changes were needed, the SSL VPO said it was through conversations that it was determined that the status quo would remain. The SSL VPO said that since they had been working with the home Sienna had been connecting with the management in the home on a weekly basis and discussing staff vacancies, recruitment of staff as well as all areas of the operational business. The SSL VPO said they were not personally involved in monitoring the care if the residents and they had provided the home with the management by walk about process. When asked if based on their opinion the staffing plan for the home was meeting the care and safety needs of resident, the SSL VPO said it was as the home had not utilized PSW agency staff and based on the weekly calls they had with the home.

The Sienna Seniors Living Vice President Operations (SSL VPO) provided Inspector #630 with a document titled “VP and Onsite Sienna team’s contributions/recommendations to the following four areas as discussed with [Inspector #630] on March 19 2019.” This document showed that on June 27, 2018, the staffing plan was reviewed. There was no other documented evidence that the staffing plan was review after the home was served Inspection #2018_722630_0019 on October 23, 2018. The document showed that on November 8, 2018, it was recommended that they home use the Sienna policy related to “suggested annual committee and program evaluation policy which includes staffing plans 31 (3)(e))." The document showed that on November 8,

2018, they reviewed the daily walk though and schedule and recommended the home "include the MOHLTC findings in current document for ongoing stability." There was no documented evidence that regular monitoring and recommendations were made by Sienna since January 31, 2019, related to the CO #007 requirement of weekly monitoring to ensure the written staffing plan was meeting the care and safety needs of the residents in the home.

During a follow-up interview, the Executive Director (ED) said the home was still actively recruiting for PSWs, RPNs and RNs to help ensure that there would be a full complement of staff in the home. When asked if based on their daily management meetings, huddles with staff and observations in the home if the current staffing plan was consistently meeting the care and safety needs of the residents, the ED said there were times when concerns were being brought forward and they would try to correct it immediately. The ED said that there were improvements that were needed especially with the PSW levels. The ED said the expectation in the home was that callbells would be responded to immediately and sometimes if staff were very busy giving care to other residents then it was the responsibility of the nursing staff and the management in the home to respond and say that someone would be there to address the request. Inspector #630 indicated that during the inspection resident had been observed waiting over ten minutes for care and asked if that met the expectations in the home, and the ED said that was not acceptable and that callbell response time had been identified as a concern during the walk troughs that had been done by management in the home. The ED said that the callbell response time had been identified as a concern especially during the toileting time after breakfast as that was a time that the staff were busy. The ED said they hoped to improve the staffing plan to meet the needs of the residents in a timely manner and to build upon the improvements that had been made in the home.

Based on these observations, interviews and clinical record review the licensee has failed to ensure the written staffing plan required for the organized program of nursing services and personal support services provided for a staffing mix that was consistent with residents' assessed care and safety needs. The licensee has also failed to comply with CO #007 from Inspection 2018_722630_0019 served on October 23, 2018, with a compliance date of January 31, 2019. The home did not document and implement a process in the home for the leadership to monitor and evaluate, at least weekly, whether the written staffing plan was meeting the care and safety needs of the residents. The home did not complete a documented review of the written staffing plan, for routine staffing levels, to

ensure it was meeting the care and safety needs of the residents and the staffing plan was not revised. The home did not provide documented evidence that all required staff had been trained on the revised staffing backup plan. (630) [s. 31. (3) (a)]

Additional Required Actions:

CO # - 004 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 #5: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to a fall for an identified resident.

During an interview a registered nursing staff member said it was the expectation in the home that after a resident had fallen that the registered staff would complete the "Post Fall Investigation" paper form and initiate a "Risk Management" assessment in PointClickCare (PCC).

A progress note for this identified resident indicated that they had sustained a fall on a specific date at a specific time and sustained an injury.

The home's policy titled "CODE CARE: Come, Assess, Reach, Evaluate" with a review date of April, 2018, stated that when a resident had a fall, a CODE CARE would be paged by the staff member who discovered the incident. All staff from that care area were required to respond immediately. Point six of the procedure stated that the recorder completed the appropriate sections of the "Post Fall Investigation" form during the fall huddle.

During an interview with a staff member they had been working when this resident fell. The staff member said that the resident sustained an injury from the fall.

During an interview with another registered nursing staff member they said that this resident had a fall and sustained an injury on a specific date. The staff member provided a "Post Fall Investigation" form to Inspector #730 for this fall and said that the assessment was not completed. Inspector #730 asked the staff member if the "Risk Management" assessment had been completed in PCC for this fall and the staff member said they were not able to find one and one should have been initiated for that fall.

During an interview a Resident Care Coordinator (RCC) acknowledged that the "Post Fall Investigation" form for this resident was not completed after this fall as per the expectation of the home. (730)

B) During an interview a registered nursing staff member told Inspector #630 that after a resident had a fall the registered nursing staff were expected to complete a head to toe assessment, complete an incident report in risk management, do post fall documentation on each shift afterwards and follow-up with care for any injuries sustained from the fall. When asked if they consistently had time to complete these assessments, the staff member said that they did for the most part but there were times when they did not have time during their shift to do all the documentation and would stay after their shift was completed to do the documentation. The staff member said that another identified resident had

sustained a fall on a specific date and they had done a rapid assessment of the resident and the documentation they had completed for this fall was a progress note. The registered nursing staff member said that they had not completed the head to toe assessment, the risk management assessment or the paper post-fall assessment form as they did not have time on their shift. The staff member said they had been the only registered staff for the entire building for four hours of the night shift and they had to prioritize their time.

The clinical record for this resident included a progress note which documented the fall which had occurred on that specific shift and indicated there was a specific injury. The clinical record did not include a documented head to toe skin assessment, a post-fall assessment incident in risk management, a hard copy post-fall assessment form or a pain assessment.

During an interview a Resident Care Coordinator (RCC) said that based on the progress notes this resident had a fall on a specific date. The RCC reviewed the clinical record for this resident and acknowledged that there was no post fall documented on a paper form or in the computer documentation system. The RCC said they spoke with the registered nursing staff member who was working at the time of the fall and it was identified that the staff member did not have enough time to complete the required documentation. The RCC said it was the expectation in the home that post-fall assessments would be completed using the designated assessment forms.

Based on these interviews and record reviews the licensee has failed to ensure that when these two residents had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. (630) [s. 49. (2)]

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. 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 :

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.

The licensee has failed to comply with compliance order #008 from Resident Quality Inspection (RQI) #2018_722630_0019 served on October 23, 2018, with a compliance due date of December 31, 2018.

The licensee was ordered to ensure that they were compliant with O.Reg. 79/10, s. 52 (2).

Specifically the licensee was ordered to:

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 that 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 specifically

designed for this purpose.

The licensee completed step a).

The licensee failed to complete steps b) and c).

The home's policy titled "Pain Management Program" with a reviewed date of February 2019, included the following under Procedures:
-"Each resident will be monitored for the presence of pain:
a) On admission, readmission, quarterly and annually by the RAI Coordinator only if triggered
b) With a new analgesic order, discontinuation of the analgesic or a change in dosage.
c) At times of significant resident condition change.
d) When a resident exhibits behaviours that may herald the on-set of pain.
e) A cognitive resident complains of pain 4 or greater
f) A resident exhibits changes in behaviour or facial grimacing.
g) A resident, family, staff or volunteer report pain is present."

-"Residents that have pain are to be treated in a step wise approach to non-pharmacological and pharmacological methods to control pain, maximize function and promote quality of life. The Interdisciplinary Team will develop the interventions. All interventions will be documented on the Resident's plan of care. Monitoring will be completed utilizing the Numerical Pain Scale (cognitive, verbal residents) or the PAIN AD tool (non-verbal, cognitively impaired residents) located under the weights and vitals tab in PCC. Triggered assessments are completed using the Caressant Care Assessment Tool located under the Assessments tab in PCC."

-"The Registered staff will:
1. Screen for presence of pain and complete a pain assessment electronically:
-On move in and re-admission
-For RAI MDS scores of 2 or more
-When resident reports or exhibits signs and symptoms of pain (greater than 4/10 for 24-48 hours) following implementation of pharmacological and/or non-pharmacological interventions (i.e. satisfactory pain relief is not achieved following interventions)."

-"The monitoring periods for nursing are:

a) On readmission – every shift for 3 days.
b) On readmission from hospital – every shift for 3 days.
c) Significant change in status – every shift for 3 days or more as warranted by the resident's condition.
d) Initiation, Discontinuation or Dosage Change – every shift for 7 days (see Physician Notification criteria page 3).
e) As needed
f) On day 4 of the admission determine the resident's baseline and record it in PCC and/or care plan."

A) On a specific date, Personal Support Workers (PSWs) stated that a specific resident was identified as having pain symptoms and received pain management in the home.

On a specific date, a PSW told the inspector that they were familiar with the specific resident. The PSW stated that when a resident demonstrated pain or discomfort they would let the nurse know right away and that the nursing staff would complete pain monitoring and assessments.

The clinical record for the specific resident included documentation which showed that the resident had been provided pain medication on a specific date which was documented as ineffective. The clinical record also included documentation that the resident had been hospitalized for a specific reason and then had returned to the home. There was also a progress note which indicated there had been a change in the resident's pain medications. There were no documented pain scales when the resident's pain medication was documented as ineffective; upon the resident's readmission from hospital; when the resident's pain medication was discontinued; or when the resident was assessed as having a significant change in status. There were no documented "Caressant Care Pain Assessment Tool" for the month of February 2019.

On a specific date, a Registered Nurse (RN) told the inspector that when a resident demonstrated pain or discomfort they would observe the resident for any signs and symptoms related to pain. The RN stated that they would complete a pain assessment identifying the resident's pain level on a scale of one through 10, or observe the resident if they were non-verbal and offer PRN medications if available. The RN stated that approximately one to two hours after completing the pain scale they would go back and check on the resident again to see if the interventions were managing their pain. The RN stated that they would use the

"Numerical" pain scale for verbal residents and the "Pain Ad" for non-verbal residents, and the monitoring was documented under Weights and Vitals in PCC. When asked when staff should complete a pain assessment, the RN stated that the pain assessment would be done at the same time as the pain monitoring under the Assessments tab in PCC. The RN stated that they were familiar with the specific resident who was able to verbalize their pain and had infrequent pain. When asked how the residents' pain was monitored, the RN stated that the resident came back from the hospital and was monitored daily by asking them about their pain, but they did not feel it was necessary to complete the pain monitoring because there was no change that required staff to complete the monitoring tool on PCC.

On a specific date, the Assistant Director of Care (ADOC) stated that the specific resident was able to verbalize pain and had interventions of pain medications to be implemented when the resident exhibited pain. The inspector and the ADOC reviewed the clinical record for the resident and the ADOC acknowledged that the pain medication provided as needed was documented as ineffective. The ADOC stated when analgesic medications were not effective, it was expected that the staff start the flow sheets for pain monitoring and complete a pain assessment. When asked what the expectation was per the home's pain policy for staff to assess and monitor the effectiveness of a medication change, the ADOC stated that they were to monitor the resident for seven days and document using the pain scales under Weights and Vitals in PCC. The inspector and the ADOC reviewed the clinical record for the resident for a specific date and the ADOC acknowledged that the residents' pain medication was discontinued on a specific date. The ADOC confirmed that there were no pain scales or pain assessments completed on that date. When asked if they would expect that a pain scale had been completed for the resident to monitor pain when their pain medication was discontinued, the ADOC stated yes. The inspector and the ADOC reviewed the residents' clinical records in PCC and the ADOC acknowledged that the resident was transferred to hospital on a specific date, was readmitted to the home on a specific date, and had a significant change in status assessment completed on a specific date. The ADOC stated that there was no pain monitoring or pain assessments completed in PCC upon the residents readmission or when the resident had a significant change in status. When asked if they would expect as per the home's pain policy that a pain assessment had been completed to re-assess the resident's pain at the time of readmission and when there was a significant change in status, the ADOC stated yes. When asked if they would expect that a clinical assessment was used to assess the resident's pain when

initial interventions were not effective, the ADOC stated yes.

B) On a specific date, Personal Support Workers (PSWs) stated that another specific resident was identified as having pain symptoms and received pain management in the home.

On a specific date, the PSW stated that they were familiar with the specific resident. The PSW stated that the resident was not able to verbalize their pain or discomfort, but staff would observe their facial grimacing. The PSW stated that the resident's pain interventions included that staff were to document and report complaints of pain.

The clinical record for the specific resident indicated there had been a change in the resident's pain medications. There was a progress note on a specific date which documented that the resident was showing signs of pain. There were no documented monitoring scales and no documented "Caressant Care Pain Assessment Tool" for a specific time frame.

On a specific date, a RN told Inspector #689 that PSW's would monitor the residents' for pain while providing care and would let the nursing staff know. When asked when staff would complete a pain assessment, the RN stated that the pain assessment would be done at the same time as the pain monitoring under the Assessments tab in PCC. The RN stated that they were familiar with the resident and they were not able to verbalize pain or discomfort and would observe the resident for signs to identify if they had pain. The RN stated that they did not monitor the resident all the time, but would ask the PSWs if the resident looked uncomfortable. The RN stated that a pain assessment would be completed for the resident if they were seen to be uncomfortable or grimacing, not just on one shift, but if pain was observed consistently. When asked how a resident was assessed for pain when determining the effectiveness of discontinuing pain medications and if a pain assessment should be completed, the RN stated that if a pain medication was not needed anymore then staff should monitor the resident's pain, observe the resident and make a progress note on each shift, but that they would not do a pain assessment. When asked how staff would know whether or not the pain medication change was effective if staff did not complete a pain assessment, the RN stated that this would be identified through the monitoring of the resident. Inspector #689 and the RN reviewed the clinical records for the resident and identified that the resident's pain medication was discontinued on a specific date. When asked if the resident's pain was monitored after the discontinuation of their

pain medication on a specific date, the RN confirmed that there was no documented pain monitoring. When asked how staff would know if the discontinuation of the medication was effective in managing the resident's pain if there were no documented monitoring, the RN stated that monitoring of pain should have happened. The RN confirmed that there were no pain assessments documented in PCC for the resident.

On a specific date, the ADOC stated that the resident was sometimes able to verbalize pain and discomfort and had pharmacological interventions to be implemented when the resident exhibited pain. The ADOC reviewed the residents' clinical records and confirmed that no pain monitoring was documented for the resident when their pain medication was increased or when their routine pain medication was discontinued. When asked what the expectation was for monitoring a resident for pain after discontinuation of a pain medication, the ADOC stated that they should be monitored for seven days. The ADOC stated that they would expect that a pain assessment had been completed for the resident at the time their medications were discontinued to assess the effectiveness of the interventions. The ADOC stated that the last pain assessment completed for the resident was on a specific date, and confirmed no pain assessments were documented in PCC before this date.

C) On a specific date, a Personal Support Workers (PSWs) stated that another specific resident was identified as having pain symptoms and received pain management in the home.

The clinical record for the specific resident indicated this resident had been requesting pain medication from staff. There was a progress note on a specific date which documented that the resident was showing signs of pain. There were no documented monitoring scales and no documented "Caressant Care Pain Assessment Tool" for a specific time frame.

On a specific date, a Registered Practical Nurse (RPN) stated they were familiar with the resident. The RPN stated that the resident was able to verbalize their pain and would complain of pain in a specific area. The RPN stated that the resident received specific pain medications and their pain was monitored and documented using the pain scales. When asked what tools would be used to assess a resident's pain level if they were unable to communicate verbally, the RPN stated they would use the Pain Ad scale. Inspector #689 and the RPN reviewed the resident's progress note on a specific date which showed that the

resident was provided breakthrough pain medication, but their pain was unable to be rated on pain scale. The RPN stated that they had documented and provided the medication to the resident on this date. When asked how they knew to provide the medication as an intervention if they did not assess the resident's pain level, the RPN stated that the resident complained of pain and then the medication was provided. When asked if it was required that a pain scale should be completed prior to providing a pain medication, the RPN stated yes. The RPN stated they would need to complete the pain scale to know what intervention to use. The RPN stated that if a resident had no relief from initial interventions they would expect that a clinically appropriate pain assessment had been completed.

On a specific date, the ADOC stated that the resident had pharmacological interventions to be implemented when the resident exhibited pain, and was sometimes able to verbalize pain. Inspector #689 and the ADOC reviewed the resident's progress note on a specific date which stated that the resident was provided pain medications as needed and that the resident was unable to rate the pain on pain scale. The ADOC stated that the expectation was that if the resident was unable to rate their pain, the Pain Ad scale should have been used. The ADOC reviewed the clinical records in PCC and confirmed that no pain monitoring or pain assessment was completed for the resident on a specific date. When asked if initial interventions were not effective, would they expect that the resident had been assessed using a clinically appropriate tool related to effectiveness of interventions, the ADOC stated yes. The ADOC stated that when the resident expressed no relief from pain then the residents' pain was not relieved by initial interventions and they should have had a pain assessment completed.

D) On a specific date, Inspector #630 observed that a specific resident had activated their call bell. The resident had stated to the inspector that they had a lot of pain in a specific area. When asked by the inspector what had been provided to them for pain the resident stated that they had been given a pain pill, but it was not working. The inspector observed a Registered Practical Nurse (RPN) arrive at the residents' room and the resident told the RPN that they had pain. The RPN asked the resident what type of pain they had and to score it. The RPN stated to the resident that they would ask another staff to come and assist them.

On a specific date, a RPN told Inspector #689 that they were familiar with the resident. When asked if the resident was able to verbalize their pain, the RPN stated yes the resident was able to express pain, was very aware of their pain and was able to talk about it. When asked what was done to manage the residents

pain, the RPN stated that the resident had received a specific pain medication at a specific time, another pain medication at a specific time.

The clinical record for the specific resident indicated this resident had been requesting pain medication from staff and had changes made to their pain medication orders. There was a progress note on a specific date which documented that the resident was showing signs of pain. There were no documented monitoring scales and no documented "Caressant Care Pain Assessment Tool" for a specific time frame.

On a specific date, the ADOC stated that the resident was able to verbalize their pain. The ADOC stated that even after the resident was provided pain medications they would still have pain. The ADOC stated that the resident had been visited by the pain consultant and had an increase in their pain medications. When asked if the resident was exhibiting pain even with the change in medication, the ADOC stated yes. The Inspector and the ADOC reviewed the residents' eMAR on specific dates which documented an increase in the resident's pain medications. The ADOC confirmed that there was no documented pain assessments completed on the dates the pain medication was changed. Inspector #689 and the ADOC reviewed the residents' clinical records which showed documentation that the resident was consistently expressing pain, often greater than four out of 10. When asked how long pain monitoring should be completed when a resident exhibited pain as four or greater, the ADOC stated that if a medication was provided and pain was greater than four out of 10, then pain monitoring was to continue using the pain scales. The ADOC stated the expectation would be that the resident should receive constant monitoring and staff should inform the physician. The ADOC stated that staff should be completing a pain assessment for when the resident complained of pain greater than four out of 10 for 24 to 48 hours as per the policy and confirmed this was not being completed.

E) On a specific date, a Registered Practical Nurse (RPN) stated that they were working in the home pursuant to a contract as an agency staff member. When asked when they would complete a pain assessment on a resident, the RPN stated on admission, and monthly or quarterly as per the policy, and this would be documented under the Assessments section in Point Click Care (PCC). When asked if they had received training in the home on the pain assessment policy, the RPN stated no.

On a specific date, the Assistant Director of Care (ADOC) stated that their role related to CO #008, was that they provided the pain management education in the home on the revised pain policy. The ADOC reviewed the home's pain policy titled "Pain Management Program" with a reviewed date February 2019, which stated "the registered staff will screen for presence of pain and complete a pain assessment electronically". The ADOC stated that according to the policy, a pain assessment should be completed on move in or readmission, including return from hospital; for a RAI MDS score of 2 or more; or when a resident reported pain greater than 4 within 24 or 48 hours following interventions. The ADOC stated that staff were required to do a pain assessment after being provided a pain medication. The ADOC stated that if the pain assessment was not satisfactory, pain monitoring would be completed through one of three options: pain scales under Weights and Vitals in Point Click Care (PCC), the pain management flow sheet (PMFS), or a pain progress note in PCC. No PMFS records were provided to the inspector for these residents during the course of the inspection. When asked when pain monitoring was expected to be completed for a resident, the ADOC stated that there were six criteria as per the policy which provided time frames for how long to monitor the resident for pain. The ADOC referred to the revised pain policy which stated "the monitoring periods for nursing are" and read the following: on readmission – every shift for 3 days; on readmission from hospital – every shift for 3 days; significant change in status – every shift for 3 days or more as warranted by the resident's condition; initiation, discontinuation or dosage change – every shift for 7 days (see physician notification criteria page 3); PRN; and on day 4 of the admission to determine the resident's baseline and record it in PCC and/or care plan. The Inspector reviewed the pain policy with the ADOC and inquired about the monitoring for the presence of pain as per the policy for the following: when a resident exhibited behaviours that may herald the on-set of pain; for when a cognitive resident complained of pain 4 or greater; when a resident exhibited changes in behaviour of facial grimacing and when a resident family, staff or volunteer reported pain was present, and asked the ADOC to explain the monitoring periods for these instances. The ADOC stated that for those instances a resident would be monitored as a "significant change in status" as listed in the policy, which stated every shift for three days.

On a specific date, Caressant Care Director of Clinical Services and Education (DCSE) stated that their role related to CO #008 was that they were part of the pain committee and reviewed and revised the home's pain assessment policy. The DCSE stated that on December 17, 2018, they and Caressant Care Regional Director of Operations (RDO) provided education to the managers on the revised

and final draft of the pain policy. When asked if the policy revisions changed or altered the pain management process in the home, the DCSE stated yes. Inspector #689 asked how they knew how long to complete a pain assessment for when a resident exhibited behaviours, if a cognitive resident complained of pain 4 or greater, or if a resident, family, staff or volunteer reported pain was present, as this was not documented in the policy. The DSCE stated that it was not provided in the pain policy, but on the pain algorithm. When asked how staff would know when to complete pain monitoring, the DSCE stated that when a resident complained of pain, then a pain assessment would be completed and was their understanding that staff were to use the pain scales only when an analgesic was provided.

On a specific date, the DCSE informed Inspector #689 that the Regional Director of Operations (RDO) could clarify information provided during their previous interview. The RDO stated that role related to CO #008 was that they were part of the pain committee and reviewed and revised the home's pain assessment policy. The inspector asked what the expectation was for monitoring and what tools should be used as per the policy, the RDO stated that according to the policy, the monitoring of pain was completed using the pain scales under weights and vitals in PCC, and the flow sheets were used as an additional tool to manage and monitor administration of pain medications. When asked what the expectation was for staff to complete a clinically appropriate assessment for pain, the RDO referenced the Pain Management Policy which stated "the monitoring periods for nursing are" and stated that staff were to complete a pain assessment under the Assessments tab in PCC for the following periods: on readmission – every shift for 3 days; on readmission from hospital – every shift for 3 days; significant change in status – every shift for 3 days or more as warranted by the resident's condition; Initiation, Discontinuation or Dosage Change – every shift for 7 days; PRN; or on day 4 of the admission to determine the resident's baseline. When asked if the heading "monitoring periods" in the policy was referencing when to complete a pain assessment under PCC, then how would staff know how long to monitor pain using the pain scales, the RDO stated that this information was not provided in the policy.

F) The licensee was ordered to ensure that they were compliant with s. 52 (2) of the Long-Term Care Homes Act (LTCHA), 2007, with a compliance due date of December 31, 2018. Specifically the licensee was ordered to:

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.

On a specific date, the Assistant Director of Care (ADOC) stated that their role related to part b) of CO #008 was that they provided staff with the pain management education on the revised pain policy. The ADOC stated that they provided one to one education for the staff on December 20, 27, 28, and 31, 2018. The ADOC reviewed the documented records maintained by the home of the education provided on the revised pain assessment policy, and stated that the names identified on the document titled “List of TLC Agency Staff That Need Pain Management Education” were agency staff who needed education. The ADOC stated that the check marks identified beside the names were the agency staff who received education with the Resident Care Coordinator (RCC). The ADOC confirmed that no education was provided to the agency staff until February 22, 2019.

Review of the home’s documented education record titled “List of TLC Agency Staff That Need Pain Management Education” showed the following:
- 4 out of 9 (44 per cent) agency staff signed and dated that they had received the education on February 22, 2019.
- 9 out of 9 (100 per cent) of agency staff did not receive education prior to the compliance due date of December 31, 2018.

Based on clinical record reviews, policy review, interviews and observations, the licensee has failed to ensure that the home’s revised “Pain Management Program” policy was complied with in order to ensure that when specific resident’s pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (689) [s. 52. (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. 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 :

The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, 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.

The licensee has failed to comply with compliance order #004 from Resident Quality Inspection (RQI) #2018_722630_0019 served on October 23, 2018, with a compliance due date of December 31, 2018.

The licensee was ordered to ensure that they were compliant with O Reg. 79/10 s. 87 (2).

Specifically the licensee was ordered to:

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.

The licensee completed step b). The licensee failed to complete steps a) and c).

Inspector #563 observed the home areas for clean and sanitary conditions. The following was identified:

Level One B Side Hallway:
- Baseboard in the hallway at the intersection near the East nursing station was missing, with a build-up of dirt and debris.

Whirlpool Room on Level One B Side:
- Shower stall next to closet where grout was stained yellow brown in colour along the lower tiled walls on either side.

Level One B Side (North, South and East Wings):

- Dust build-up noted in multiple wall grates.
- Multiple resident rooms where the floor perimeter around the door frames and room had a build-up of dust, dirt and debris. Baseboards near the bottom of resident doors were peeled off and dust and dirt had accumulated.
- Brick wall along the hallway behind the double doors near the B dining room had a build-up of dirt and debris along the perimeter of the floor and in between the brick.
- Build-up of what appeared to be sand outside one resident room in East wing and located in the right corner of the door frame.
- Multiple resident bathrooms had a build-up of a white hardened substance on the faucets, a dark brown build-up between the floor tiles, a build-up of dirt around the base of toilets, brown wall splatter behind one toilet, dust with a black residue and hair noted along the assist bars connected at the back of toilet seats, a build-up of dust, hair, webs, dirt and debris along floor perimeter and under bathroom sink counters and cobwebs behind resident toilets. Water valves behind toilets were covered in dust and webs.
- A resident stated that they saw “little black bugs near the toilet” and pointed to the counter on the floor. Small black round particles were noted in this area.

The Caressant Care (CC) Director of Operations (DOO) stated that the weekly monitoring process was developed and partially implemented because it was completed for each week in November, but not at all for December 2018, only the first week of January 2019 and nothing for February 2019. The DOO provided a “Weekly Walk – Through Checklist Environmental Services/Maintenance person” form dated in January 2019 and stated this was the only weekly checklist completed that they could find. The DOO also explained that they completed a Monthly Housekeeping Audit of all resident rooms in the home. The audit documentation identified areas that needed cleaned, painted, repaired or replaced. The CC Director of Quality and Privacy was also present during the interview.

Inspector #563 showed the DOO and the CC Regional Director photographs taken of the build-up of dirt, dust, debris and cobwebs. The DOO verified that the procedures developed to ensure the home was clean and sanitary were not implemented.

The "Weekly Walk – Through Checklist Environmental Services/Maintenance person” form documented the following: "Common Areas"; "Resident Rooms"; and "Safety." This weekly checklist did not include monitoring to ensure that the

home, furnishings, equipment were kept clean and sanitary.

The Director of Operations (DOO) verified it was the expectation of the home that all resident rooms, including floors, bathrooms floors, toilets, sinks, mirrors and counters be cleaned daily by the housekeeping staff and twice a week there was a deep clean of two resident rooms in each home area. The vents were not documented as part of the audits and checklists completed by the Environmental Services Supervisor (ESS) and DOO stated this was a monthly routine task built in maintenance care for the exhaust fans, but it was not closed as completed for February 2019. The DOO shared that it was documented as “NEW” in maintenance care when it still required completion and would change to “CLOSED” when the task was done. The exhaust fans were still documented as “NEW”. The DOO also stated that a “Weekly Walk – Thorough Checklist” was to be done daily by the Executive Director “ED”, “Maintenance person”, “Activation”, “Dietary”, and the Director of Nursing “DON” and it was the responsibility of the person doing the checklist to be keep them. The DOO verified that the daily walkabouts and documentation was completed for one week in January 2019, by the ED with nothing further. The DOO also verified that the "Weekly Walk – Through Checklist Environmental Services/Maintenance person” form did not include monitoring to ensure that the home, furnishings and equipment were kept clean and sanitary and the checklist did not identify who completed the audit.

The DOO provided Inspector #563 with copies of the following documents:
- “Weekly Walk – Through Checklist for Environmental Services/Maintenance person” completed the week of January 7 and February 27, 2019;
- “Weekly Walk – Through Checklist – Management” completed the week of January 21, January 28, February 4, 2019;
- “Weekly Walk – Through Checklist – Executive Director” completed the week of December 31, 2018.

Inspector #563 made additional observations of B side. The following was identified:

Level One B Side (North, South and East Wings):
- Multiple resident rooms where the floor perimeter behind resident doors, around the door frames and room had a build-up of dust, dirt and debris.
- Brick wall along the hallway behind the double doors near the B dining room had a build-up of dirt and debris along the perimeter of the floor and in between the brick.

- Build-up of what appeared to be sand, hair and dust outside one resident room in East wing and located in the right corner of the door frame still present since February 25, 2019.
- Multiple resident bathrooms had a build-up of a white hardened substance on the faucets, a dark brown build-up between the floor tiles, a build-up of dirt around the base of toilets, brown wall splatter behind one toilet, dust with a black residue and hair noted along the assist bars connected at the back of toilet seats, a build-up of dust, hair, webs, dirt and debris along floor perimeter and under bathroom sink counters and cobwebs behind resident toilets. Water valves behind toilets were covered in dust and webs.
- A resident bathroom had yellow dried build-up at base of toilet and around bolt caps, floor perimeter had build-up of dark black brown debris and dirt, and far corner floor under the sink near doorway with a build-up of hair, dust and debris.
- Wall ventilation near “kitchen” door in the South wing build-up of dust observed.

The housekeeper stated the cleaning of resident washrooms included sweeping the floor, cleaning the mirror, wall spot cleaning, dusting, cleaning the toilet, emptying the garbage and washing the floor every day. The resident rooms included dust mopping the floor, and if night stands and wardrobes needed dusting. A total room cleaning, on average, would occur every three months where all furniture would be moved out from the walls and corners would be dusted for cobwebs, along the window curtain rods, the entire room floor would be dust mopped, the bed frame, mattress and headboard would be washed, then the floors washed, and window ledges, lights and furniture wiped. The Housekeeper explained that they would have to use a “scrubby” to remove the ground in dirt around resident doorways and door frames. The wall vents were to be cleaned by the maintenance staff, but housekeeping would also wipe them off for dust. The housekeeper also verified that there should not be an accumulation of cobwebs, dust, debris and dirt behind toilets and under sink cabinets if the floors were cleaned daily. They said for the dark black/brown build-up at the corners where the lid was connected or the assist bars were connected to the toilet basins on B side, the housekeeping should be notifying maintenance to remove the assistive device so that the area could be cleaned.

The Caressant Care Corporate Environmental Services Consultant (CESC) stated that the home was to complete a housekeeping audit monthly for general observations of four resident rooms and it was the responsibility of the Environmental Service Supervisor (ESS) and the Executive Director to follow up to ensure the housekeeping expectations were being met. The purpose of this

audit was to review four resident rooms per wing because the home have different housekeepers doing different sections. The ESS would then review the documentation and look for trends. The audit would then be calculated where a higher percentage would indicate that housekeeping tasks were being performed and completed for the items listed as part of the audit. Inspector #563 shared that multiple resident bathrooms on B side were observed for a dark brown build-up between floor tiles around toilets. The CESC stated that the housekeeping staff were to use a steam cleaner if they had one. The CESC shared that a steam cleaner was being ordered “today”, but that all the floors on B side were being replaced in the washrooms. The CESC also stated that new counters were being installed in all B side bathrooms and the old cabinets removed. The flooring would go straight back to the wall so that those edges were cobwebs, dust, debris and dirt accumulated under sink cabinets would be eliminated. Also, part of the bathroom refurbishing was to install the wall mounted grab bars. The CESC stated this would eliminate the need for assist bars to be mounted to the basin on the toilet where dark black/brown build-up was observed. The ground in dirt around resident doorways, baseboards and door frames require a steamer to remove the build-up, but that the floors should be mopped every day with a microfiber system. The CESC verified that the “Weekly Walk – Through Checklist Environmental Services/Maintenance person” form was a safety check and the home, furnishings, and positioning aids were not monitored for cleanliness using that form. The CESC was asked what weekly monitoring process was developed and implemented to ensure the home was clean and repaired and the CESC replied the home created a “Weekly Housekeeping Audit” from the “Monthly Housekeeping Audit” already in use.

The Caressant Care Nursing & Retirement Homes Ltd. policy titled “Housekeeping Audit” last reviewed September, 2018, stated, “The housekeeping audit shall be completed on a monthly basis to ensure resident rooms meet the Housekeeping standards of the facility and of the Ministry of Health and Long Term Care.” The procedures in this policy stated, “Complete the forms as follows: choose 4 rooms at random to be inspected; inspect the room as per the log checklist and identify any deficiencies; total all checklist boxes and all positive outcomes to determine a percentage; monitor and evaluate the percentage month over month noting any trends; and 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 Environmental Services Supervisor (ESS) stated they had worked for

Caressant Care Woodstock since December 2018, as the designated lead for the housekeeping, laundry and maintenance service programs. The ESS stated that there were routines that housekeeping followed to ensure the home was clean and sanitary that included a deep cleaning schedule and daily cleaning guidelines for resident rooms and common areas and the tub rooms. There was also an A1, A2 and B Shift Housekeeping Routine and a Student Housekeeping Job Routine. The ESS stated the expectation for cleaning resident rooms, including floors and bathrooms was daily. Cleaning included anything that can be easily reached by the housekeeping staff, including wall intake vents. The ESS shared that walk-throughs and checklists were completed home to ensure the furnishings and equipment were kept clean and sanitary. The ESS also shared that the “Weekly Housekeeping Audit” was created to comply both CO #004 and CO #005 from Inspection 2018_722630_0019 related to weekly monitoring. The ESS completed this form weekly until they were off work for approximately three weeks and verified that it did not include the clean and sanitary conditions of the home and furnishings. The "Weekly Walk – Through Checklist Environmental Services/Maintenance person” form did not include the staff responsible for monitoring. The form did not identify the person completing the audit.

Inspector #563 made additional observations regarding the cleanliness of the home. The following was identified:

Level One B Side (North, South and East Wings):
- Multiple resident rooms where the floor perimeter behind resident doors, around the door frames and room had a build-up of dust, dirt and debris.
- Brick wall along the hallway behind the double doors near the B dining room had a build-up of dirt and debris along the perimeter of the floor and in between the brick.
- Resident bathroom toilet where assist rails connected to the back basin had a build-up of greenish yellow and brown fluid and dust along the entire device, and the floor along perimeter of the toilet had dark brown black build-up along toilet and between floor tiles with brown yellow staining, bathroom baseboard peeled from the wall with wall damage and peeling paint and build-up of dirt and dust at the corner
- East hall: build-up of dust along upper edge of baseboards along entire hallway, both sides and small area of wall near the double doors was bricked and painted white with a build-up of dust, dirt and debris along the perimeter.
- Wall vent near E29 still covered in dust.
- Baseboards chipped and peeling at corner edge with dried paint on top of old

dust and dirt on the floor.

Level One and Two A:
- Near room A221, a water cooler was observed with a build-up of dust and dirt behind the water cooler and the floor was marked with brown streaks and a build-up of a dark brown substance between the floor tiles.

"Global" Fans:
- Wall mounted rotating fan near room E5 was covered in layered dust and hair on the entire steel cage and fan blades.
- Wall mounted rotating fan near room N31 was covered in layered dust and hair on the entire steel cage and fan blades.

The Sienna Senior Living (SSL) Director of Operational Effectiveness (DOOE) stated Sienna recommended housekeepers to be assigned to one floor for consistency and to get to know the residents and the floor by using a primary care model to develop a stronger housekeeping ethic. Inspector #563 asked what weekly monitoring process was developed to ensure the home, furnishings and equipment was kept clean and sanitary and the SSL DOOE replied that each manager completed a full daily walk around and made recommendations. Inspector #563 provided a document completed by the SSL DOOE one day in February 2019 titled the “Weekly Walk-Through Checklist – Environmental Services/Maintenance Person” and the SSL DOOE verified that the checklist appeared to be general and did not include the monitoring of the clean and sanitary conditions of the home and furnishings. The SSL DOOE then stated that there was also a “Weekly Walk-Through Checklist – Management” tool used and again verified that it too did not include the monitoring of the clean and sanitary conditions of the home and furnishings. The SSL DOOE “Weekly Walk-Through Checklist – Management” tool included “is furniture free of rips and stains” but that this was disrepair, not cleanliness. Inspector #563 provided a document titled, “Weekly Housekeeping Audit” completed by the SSL DOOE once in February 2019 and they verified that it was the tool developed and used to ensure compliance with CO #004 related to housekeeping. The SSL DOOE also verified that the “Weekly Housekeeping Audit” only included resident rooms and not the home and furnishings in common areas. The SSL DOOE also verified that the “Weekly Walk-Through Checklist – Management” did not include the staff responsible for monitoring and stated that “management” could mean the Resident Care Coordinator, Assistant Director of Care, Director of Care or the Executive Director and acknowledged that the completed forms did not identify

the staff member who completed the audit.

Based on observations, staff interviews and record review of policies and procedures related to the housekeeping of resident rooms and common areas, the licensee failed to ensure that procedures were developed and implemented for cleaning of the home, resident bedrooms, and common areas; and the cleaning and disinfection of assistive aids and positioning aids used in the resident washrooms. The licensee also failed to comply with Compliance Order #004, as they failed to ensure a weekly monitoring process was developed and implemented, including the staff responsible for monitoring, to ensure that the home, furnishings, equipment and residents' assistive aids and positioning aids were kept clean and sanitary with a compliance due date of December 31, 2018. (563) [s. 87. (2)]

Additional Required Actions:

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

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 89. Laundry service

Specifically failed to comply with the following:

s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,
(a) procedures are developed and implemented to ensure that,
(i) residents' linens are changed at least once a week and more often as needed,
(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,
(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and
(iv) there is a process to report and locate residents' lost clothing and personal items; O. Reg. 79/10, s. 89 (1).
(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents; O. Reg. 79/10, s. 89 (1).
(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and O. Reg. 79/10, s. 89 (1).
(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Findings/Faits saillants :

The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there was a sufficient supply of clean linen, face cloths and bath towels always available in the home for use by residents and that the linen, face cloths and bath towels were kept clean and sanitary and were maintained in a good state of repair, free from stains and odours.

An anonymous complaint was reported to the Ministry of Health and Long-Term Care (MOHLTC) and documented concerns over the home's shortage of linen and towels and this had been an ongoing issue for the past few months. The caller stated during the evening shifts the staff had no towels or washcloths for bathing and washing residents. The complainant also stated that beds were not being made properly due to lack of proper bed covers. There had also been cases where residents have been sleeping on partially uncover mattresses.

The Personal Support Worker (PSW) was observed organizing towels for

personal resident use and the PSW stated each resident required one half towel, one blue peri towel and one face cloth each shift. The PSW stated that typically PSWs were always short towels and it had been worse the last month or so. The PSW shared that they did not have enough half towels for resident care “today”. The PSW also stated that they would go to the tub room or search for unused towels from residents who were scheduled for a full bath. A second PSW walked by and stated that there was often not enough clean towels for evenings and sometimes there was just not enough for any shift. The PSW also stated that they would look to see if there were any leftovers from other residents; particularly those who received a full bath that day and would still have their personal care towels available. The PSW was asked if there was ever a shortage of bed linens and the PSW replied they were short fitted sheets and mostly on days. The second PWS stated two flat sheets were used when there was not enough fitted sheets. Inspector #563 and the PSWs made observations of several towels and peri cloths that were rough with frayed edges and both PSWs said that the towels were old and in disrepair.

Two PSWs were observed folding and sorting towels for personal resident use at the nursing station on Level Two A Side. One PSW stated they work evenings and the PSWs were always short towels. The PSW stated most towels were discoloured and frayed because they are washed up to six times a day and come back faded and rough. The second PSW added that two days ago the evening shift did not have one towel to provide care. Inspector #563 asked if residents received the personal care they needed when there were not enough towels and the PSWs stated they were given “baby wipes”. One PSW took the Inspector to A247 Tub Room and stated there was only enough towels for the nine baths scheduled, but at times PSWs take the bath towels, wet half of it to clean the residents and use the other half to dry them. Both PSWs shared they have reported the issue to management, but have been accused of hiding them.

Inspector #563 observed specific residents' bedding which were in a state of disrepair.

The "Laundry Room" on the Retirement Home (RH) side was observed by Inspector #563. One Guest Attendant (GA) explained that a guest attendant did the laundry for both the retirement and the Long Term Care (LTC) sections of the home. The GA explained that the linen was brought over in bags from the LTC home, it was then sorted and the towels, sheets, aprons and bed spreads on days were washed first which left the personal resident clothing as the last priority. The

GAs said that if the LTC linen did not get taken over to the Laundry Room then it did not get washed. The GAs said that the LTC home did not have enough supplies for all five wings. The GAs said that if the laundry did not arrive by noon then the laundry supply for evenings would be short because each cycle took an hour to wash and another hour for drying and folding. The GA stated they washed maybe a 100 face cloths on a good day and usually only about 80. The other GA stated there was not enough linen for one shift, let alone two shifts, never mind two days. The GA also shared that they tried to divide the clean laundry between the five LTC wings so they had what they need, but they knew it was not enough. The GA said even if they washed all the linens from days for evenings on time, there was not enough supply for all the residents in the LTC home. The GA stated that they needed 300 towels and 300 face cloths to cover both shifts and the current supply was less than 100 total for the entire home. Guest Attendants (GAs) stated they also had concerns related to the condition of the linens and towels. The towels were frayed and discoloured pink, stained and the edges were torn. The GA stated they could not afford to pull the towels from circulation because the PSWs could not afford to go without them. The GAs both stated that the bed spreads were for the LTC Level One B Side and were at least 25 years old. Inspector #563 and the GAs observed bed spread together and they had frayed edges and there were multiple holes in multiple bed spreads. The white cotton bed spreads were also observed for Level One and Level 2 A Side and they too were observed pulled and frayed. The GA stated again that if they were to take them out of circulation then the residents would not have any.

Inspector #563 then observed the laundry supply and soiled linen carts on all five LTC home areas. The linen supply carts had linens and towels available but the supply did not appear to be enough for all residents in each area.

Inspector #563 observed that a resident’s fitted sheet had many holes and pink bed spread had frayed edges all the way around. Another resident’s pink bed spread was observed to have had frayed edges all the way around. The Level One B Side East wing clean linen cart was contained three fitted sheets and all of them either holes, runs, rips, or stains.

A PSW stated they would discard the linen in disrepair by throwing it in the garbage and would tell the nurse. A second PSW also stated they would throw out any linens or towels in disrepair and notify the Director of Care. Neither PSW knew how the home tracked this process. The first PSW stated the home did not have enough face cloths or towels to discard any even if they were in disrepair

and stated they would be happy to have towel and sheets with holes because at least that would mean they had some and shared the home was short fitted sheets “today”.

The Environmental Service Supervisor (ESS) stated they were the designated lead for the laundry service program in the home. The ESS stated the home does a total linen count annually and it was done in March 2018. The ESS stated that the “Discarded Linen Inventory” was completed monthly by the Guest Attendants who were to remove the discarded laundry items from circulation and document on the number discarded as part of the inventory form. Inspector #563 showed the ESS photographs of towels, linens and bedspreads with tears, holes, discolouration and stains. The ESS stated that there were towels and linens in use presently that were in a state of disrepair.

The ESS and the Caressant Care Corporate Environmental Services Consultant (CESC) reviewed the "Linen Count March 2018" form and explained that it was an annual audit of the linen supply in the home at the time of the audit. The CESC stated it represented each of the five home areas as well as the number of linens counted that were located in the actual laundry room on the Retirement Home side. The ESS stated the "Total" column was the total linen count in the home, the "Required" column was the supply required to provide resident care and the "Order" column was what the home needed to purchase. The ESS also clarified that the "Declared Linen Inventory" was completed monthly by the Guest Attendants who worked in the laundry room and represented the number of linens declared in disrepair and removed from circulation.

The home's "Linen Inventory" policy last reviewed April 2018 stated the “Nursing Home staff and Retirement Home staff will conduct an annual count of all linens in circulation and in storage”. “The quantities and types of linens discarded will be communicated to the Executive Director or delegate, who places a monthly linen order to ensure replacement of discarded items.” “At all times there will be a supply of clean linen (including sheets, pillow cases, blankets, towels, face cloths, bibs, and continence care supplies) sufficient to meet resident needs, readily available for use.”

The Caressant Care Nursing & Retirement Homes Ltd. "Repair and Disposal of Linens" policy last reviewed April 2018 stated, "Linens shall be maintained in a good state of repair and free of stains". "Linen shall be inspected for quality at the time of laundering" and "if an item to be used by the nursing staff is identified as

being in a poor state of repair, having stains, etc., it will be brought to the attention of the Charge Nurse. The Charge Nurse will then communicate this to the Director of Care." "The frequency of such incidences will be monitored by the Director of Care. If they become excessive, the Director of Care will discuss with the Executive Director who in turn will communicate with the Retirement Home Manager (if applicable)."

The Caressant Care Nursing & Retirement Homes Ltd. "Pandemic Planning" policy effective March 2011 stated as part of the home's preparedness that the facilities have an emergency stock pile of linens and a four to five day supply was recommended.

The ESS provided documentation related to the laundry supplies in the home which included the following:

The Woodstock Nursing Home "Linen Count March 2018" which stated "Product requirements are based on 4 days supply as per Pandemic policy." This form documented the following:
- White Facecloth "based on 3 per/day": there was a total of 250 counted in the home, but 1968 were documented as required with 1718 that needed to be ordered.
- Hand Towel "based on 2 per/day": there was a total of 705 counted in the home and 1312 were documented as required with 607 that needed to be ordered.
- Blue Wash Cloth "based on 2 per/day": there was a total of 444 counted in the home and 1312 documented as required with 868 that needed to be ordered.
- Bath "based on 1 per/day": there was a total of 214 counted in the home and 656 were documented as required with 442 that needed to be ordered.
- Fitted Bottom Sheet "based on 1 per/day": there was a total of 260 counted in the home and 656 were documented as required with 396 that needed to be ordered.
- Plain Top Sheet "based on 1 per/day": there was a total of 63 counted in the home and 656 were documented as required with 593 that needed to be ordered.
- Bed Spread "based on 1 per/day": there was a total of 142 counted in the home and 164 were documented as required with 22 that needed to be ordered.
- Bibs "based on 3 per/day": there was a total of 263 counted in the home and 1968 were documented as required with 1705 that needed to be ordered

Based on a review of the documentation of the linen orders and the annual count of all linens that occurred in March 2018 did not match what was ordered on

March 21, 2018 and again on April 30, 2018.

Based on these observations, interviews and record reviews, the licensee has failed to ensure there was a sufficient supply of clean linen, face cloths and bath towels always available in the home for use by residents in all five home care areas. Linen, face cloths and bath towels were not kept clean and sanitary and were not maintained in a good state of repair, and free from stains. (563) [s. 89. (1)]

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 O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

The licensee has failed to ensure that each resident who was unable to toilet independently some or all of the time received assistance from staff to manage and maintain continence.

A) During the inspection, Inspector #630 observed that the callbell for an identified resident was activated and a staff member went into the room and the resident said they needed to use the bathroom. The staff member told the resident that they would tell the other staff and left the room. Based on this observation this

resident waited at least 18 minutes for continence care from staff.

During the inspection on another day, when Inspector #630 arrived in a specific area of the home and it was observed that there were three callbells activated including the one for this identified resident's room. Inspector #630 observed a staff member tell the resident that they would be back to help them and turned off the callbell. Based on this observation this resident waited at least seven minutes for continence care from staff.

During the inspection on another day, Inspector #630 observed that the callbell for this resident's room was activated as well as for two other rooms in area. At a specific time a staff member went into the resident's room and said to the resident that they would be right back and the resident responded by saying that there were three people waiting. Based on this observation this resident waited at least 15 minutes for continence care from staff.

During an interview this identified resident told Inspector #630 that they required assistance from staff with their continence care including a specific type of care.

The clinical record for this resident included a "Caressant Care Assessment of Resident Continence Status" which indicated that this resident had specific care needs related to continence care. The plan of care for this resident included specific interventions for staff related to continence care.

During an interview, a staff member said they would know what care a resident required related to continence care by the kardex and from knowing the residents in the home. The staff member said they were familiar with this resident and they required specific care with toileting from staff.

B) During the inspection, when Inspector #630 arrived in a specific area it was observed that the callbell for another identified resident was activated and there were no staff in the hallway. At a specific time a staff member went into the resident's room and said that they would be back to assist the resident and turned off the callbell. Based on this observation this resident waited at least 32 minutes for continence care from staff.

During the inspection on another day, Inspector #630 observed that the callbell. The resident told the inspector that they had rang their callbell and were waiting for assistance from staff to use the toilet. Based on this observation this resident

waited at least 18 minutes for continence care from staff.

During an interview the resident told Inspector #563 that they had rung the bell for assistance with toileting care and were waiting for assistance from staff.

During a follow-up interview the resident told Inspector #630 that they had concerns with the care in the home as they had to wait for care. The resident said that they would have to wait for assistance with the bathroom and that they thought there were times when they had to wait over an hour for assistance. The resident said that there were times when staff did not assist them in time to prevent incontinence. The resident said they had no other concerns about the home other than they did not seem to have enough staff.

The clinical record for this resident included a "Caressant Care Assessment of Resident Continence Status" which indicated that this resident had specific care needs related to continence care. The plan of care for this resident included specific interventions for staff related to continence care.

During an interview a staff member told Inspector #630 that they would know what care residents required with continence care and toileting from the plan of care and from knowing the residents. When asked if residents had been receiving the assistance with toileting and continence care that they required in the home, the staff member said to the best that the staff were able but they needed more staff as residents were sometimes having to wait for care. The staff member said that this resident required assistance from staff to use the toilet as part of their continence care.

During an interview a staff member told Inspector #630 that staff were expected to answer callbells as soon as possible. The staff member said that it was hard for staff to answer the callbells as expected as there were only three staff for that area and they could not leave residents unattended. The staff member said that there was about an hour and a half on every shift when staff were on breaks there were only two PSWs available to assist residents. The staff member said that most of the residents in that area required two staff for transfers and care and it meant residents had to wait for care with toileting at times.

During an interview, the Assistant Director of Care (ADOC) told Inspector #630 that it was the expectation that staff would respond to the callbells as soon as possible. When asked if they had identified any concerns with residents not

receiving the continence care they required in the home, the ADOC said there had been some issues. The ADOC said if the PSWs were busy with one resident and then there was another callbell activated it could take 10 to 15 minutes to give care and would then be a delay in the response to the other resident.

During an interview the Executive Director (ED) said the expectation in the home was that callbells would be responded to immediately and sometimes if staff were very busy giving care to other residents then it was the responsibility of the nursing staff and the management in the home to respond and say that someone would be there to address the request. Inspector #630 indicated that during the inspection resident had been observed waiting over ten minutes for continence care and toileting and asked if that met the expectations in the home, and the ED said that was not acceptable and that callbell response time had been identified as a concern during the walk troughs that had been done by management in the home. The ED said that the callbell response time had been identified as a concern especially during the toileting time after breakfast as that was a time that the staff were busy. The ED said they hoped to improve the staffing plan to meet the needs of the residents in a timely manner and to build upon the improvements that had been made in the home.

Based on these observations, interviews and record reviews the licensee has failed to ensure that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence. (630) [s. 51. (2) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

The licensee has failed to ensure that the home had a dining and snack service that included proper techniques to assist residents with eating, including safe positioning of residents who required assistance.

On two specific dates Inspector #689 observed an identified resident in a specific position while receiving feeding assistance from a Personal Support Worker (PSW).

Review of the residents' care plan in Point Click Care (PCC) showed a focus of eating, with a goal related to adequate nutrition and hydration. The care plan showed documented interventions that the resident was at nutritional risk and required a specific level of assistance with eating.

On a specific date, Inspector #689 and the Registered Dietitian (RD) observed the resident in a specific position while receiving feeding assistance from a PSW. When asked what the expectation was related to proper techniques to assist residents with eating, including safe positioning of residents who required assistance with eating, the RD stated that the expectation in the home was that the resident would be seated in an appropriate position while receiving feeding assistance. The RD said that the resident was not in a safe position while receiving feeding assistance. The RD stated that the resident did not have any swallowing concerns related to eating. The RD stated that they expected that the resident would be positioned safely while eating and that it needed to be addressed.

On a specific date, a Resident Care Coordinator (RCC) stated that the RD had

mentioned their concerns related to the positioning of the resident during feeding assistance at the management meeting that morning. The RCC stated that they had a discussion with the resident to ensure they were sitting up properly during meals. When asked how the home ensured appropriate positioning for residents while eating, the RCC stated that everyone was trained during mandatory education on proper body positioning while eating and PSWs had training during yearly education. The RCC stated that it was their expectation that the resident should have been in an upright position while receiving feeding assistance.

The home failed to ensure that proper techniques were used to assist the resident with eating, including safe positioning when they required feeding assistance. (689) [s. 73. (1) 10.]

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 has a dining and snack service that includes, at a minimum, proper techniques to assist residents with eating, including safe positioning of residents who require assistance, to be implemented voluntarily.

Issued on this 23rd day of December, 2019 (A3)

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

Original report signed by the inspector.

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Operations Division
Long-Term Care Inspections Branch

Division des opérations relatives aux soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du rapport public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by MELANIE NORTHEY (563) - (A3)
Inspection No. / No de l'inspection :	2019_722630_0005 (A3)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	029560-18, 029562-18, 029563-18, 029564-18, 029566-18, 029567-18 (A3)
Type of Inspection / Genre d'inspection :	Follow up
Report Date(s) / Date(s) du Rapport :	Dec 23, 2019(A3)
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 :	Carol Bradley

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

To 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:

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 001

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

Linked to Existing Order / Lien vers ordre existant: 2018_722630_0019, CO #001;

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 an identified resident and any other resident in the home, as specified in their plan.

b) Ensure an auditing process is developed and fully implemented 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 plans. This auditing process must be documented including the auditing schedule, the names of the people conducting the audit, the residents who have been audited, the results of the audit and what actions were taken in regards to the audit results.

Grounds / Motifs :

1. The licensee has failed to comply with Compliance Order (CO) #001 from #2018_722630_0019 issued on October 23, 2018 with a compliance due date of December 31, 2018.

The licensee was ordered to ensure that they were compliant with s 6. (7) of the LTCHA.

Specifically the licensee was ordered to:

a) Ensure that the care set out in the plan of care related to mobility and falls prevention was provided to the resident as specified in their plan.
b) Ensure that a monitoring process was 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 was to be documented.

The home failed to complete steps a) and b).

The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) on a specific date which reported that an identified resident had fallen.

During interviews with specific staff members they said that this identified resident had a specific intervention in place for falls prevention.

A review of the current care plan for this resident showed it included this specific intervention as part of falls prevention.

During the inspection, Inspector #730 observed on multiple occasions that this resident did not have this specific intervention in place.

In an interview with a Resident Care Coordinator (RCC) and the Assistant Director of Care (ADOC) they indicated they were familiar with CO #001 from Inspection #2018_722630_0019. The RCC stated that it was their expectation that this interventions would have been in place for this resident related to their falls prevention plan of care. When asked how the home complied the order to ensure that the care set out in the plan of care related to mobility and falls prevention was provided to the resident as specified in their plan, the RCC said the interventions should be on Point of Care (POC) for tasks for the staff as well as on the kardex and the care plan and this was not a change of practice. The RCC said they thought the RAI Coordinators would have documentation as they were to ensure that the documentation of care was completed. The ADOC said they were auditing regularly and doing weekly walkabouts to identify individuals with high risk factors for falls.

The ADOC said they would check one resident room each week to make sure all the interventions were in place. When asked if they would provide documentation to support the audits and walkabouts, the ADOC said they thought someone else had provided Inspector #730 with this information and did not have any documentation to provide.

In an interview a Resident Assessment Instrument (RAI) Coordinator said they had been involved in working on complying CO #001 regarding mobility and falls preventions and it was an ongoing process. RAI Coordinator said their role was to ensure the plan of care had been updated with interventions. When asked if they were part of ensuring that staff are providing care as per the care plan regarding falls prevention and management, they said they thought that was the Resident Care Coordinators (RCCs) who dealt with that.

In an interview the Caressant Care Director of Operations (DOO) told Inspector #630 that they were not able to find documented evidence that management staff in the home had been doing regular audits of the care provided to residents in the home and could provide no documented audits or walkabouts completed for February 2019.

In an interview the Director of Operations (DOO) told Inspector #730 that the process that had been developed to monitor the falls prevention care was that one of the Resident Care Coordinators (RCCs) would use the risk management tool to make sure the resident had what they needed and would be out on the floor checking. The DOO said they were not sure how the process had been implemented that there was no plan fully implemented within the home to ensure that the plan of care for residents at moderate or high risk for was falls were being provided to the residents as specified in the plan. The DOO said that it did not look like there was any tool developed for that purpose within the home.

The licensee has failed to ensure that the care set out in the plan of care was provided to this identified resident for falls prevention, as specified in the plan. The licensee also failed to comply with Compliance Order (CO) #001 from #2018_722630_0019 issued on October 23, 2018, as they did not develop and fully implement a documented monitoring process, to ensure that the plan of care for residents at moderate or high risk for falls were being provided to the residents as specified in their plan. (730) [s. 6. (7)]

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

The 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 1 as it related to 1 out of 3 residents reviewed. The home had a level 5 history as they had multiple non-compliances with at least one related order to this section of the legislation that included:

- Written Notification (WN) and Compliance Order (CO) issued October 23, 2018 (2018_722630_0019) with compliance due date December 31, 2018.
- 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). (730)

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 002

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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;
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and
(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).

Order / Ordre :

The licensee must be compliant with s. 15 (2)(c) of the LTCHA.

Specifically the licensee must:

a) Ensure the home, furnishings and equipment are maintained in a safe condition and in a good state of repair.

Grounds / Motifs :

1. The licensee has failed to ensure that the home, furnishings and equipment were maintained in a safe condition and in a good state of repair.

A Written Notification (WN) and Compliance Order (CO) #005 was issued October 23, 2018 during the Resident Quality Inspection (RQI) #2018_722630_0019 with a compliance due date of December 31, 2018. The home was ordered to be compliant with O.Reg. 79/10 s. 90.(1)(b) as part of the organized program of maintenance services under clause 15 (1) (c) of the Act.
Specifically the licensee was ordered to:

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."

The home was compliant with Ontario Regulation 79/10, s. 90 (1)(b) as they completed part a), b), c) and d). The home failed to complete part e) to ensure the home, furnishings and equipment were kept in good repair.

The home areas were observed for disrepair and Inspector #563 identified the following:

Level One and Two - A Side:
- Room A139 six of six armchairs legs remained scuffed,
- Room A239 four of four armchairs legs remained scuffed,
- Multiple flooring tiles lifted and peeling, chipped at the corners and broken, and
- Tub Room A247 had multiple missing wall tiles near the toilet and bathtub along the wall perimeter and the corner wall near the baseboard behind the tub room door had two chipped tiles.
- Flooring throughout was lifting and peeling and the corners were cracked in areas, as well in the stairwells.

Level One - B Side Hallway:
- Floor tiles chipped in multiple areas leading towards the North, South and East wings, and
- Baseboard was still missing and not replaced or repaired in the hallway at the East wing intersection.

Resident Rooms - Level One B Side:

- Multiple corner plastic covers on doorframes peeled off, cracked or chipped.
- Multiple baseboards and the corner walls had chipped paint and exposed glue and brick.
- Multiple resident bathrooms had chipped paint, the caulking around sinks were cracked and peeling with white hard build-up of residue on faucets and taps, faucets were chipped and peeling, cupboards were chipped along the lower edge and baseboards were peeling with wall disrepair and stained flooring.
- Multiple resident door frames were chipped with dried paint splatter on the floor, baseboards peeled in resident rooms and walls had noted areas of disrepair.
- Baseboards chipped and peeling at corner edge of doorframes with dried paint on top of old dust and dirt on the floor.
- Missing baseboard on either side of the hall and where the baseboard was pulled away from the floor had a build-up of dust, hair and debris.
- Floor tiles indented with cracks and build-up of dust and dirt, door frame had a build-up of dirt and dust at the corners.

Inspector #630 interviewed a resident who reported they had damaged walls in their private room. The resident pointed to an area by the bathroom door and on the wall across from the bathroom and stated the disrepair had been there a long time. The resident stated the room needed the drywall fixed and a coat of paint. The resident also reported concerns of disrepair in their bathroom. Inspector #630 observed an area of wall damage beside the bathroom with a hole in the wall near the floor approximately 10 cm in length. As well there was a damaged area about one meter in length near the floor on the wall across from the bathroom with paint and drywall scraped.

The Caressant Care Director of Operations (DOO) explained that they completed a "Monthly Housekeeping Audit" and that the documentation identified areas that required cleaning, painting, repairs or replacement in all resident rooms in the home.

The Woodstock Nursing Home (NH) Environment Audit for Level One B identified the following:
- 19 washroom floors needed replaced, all rooms required strip and wax
- 16 washroom walls needed painted
- 21 sinks and fixture faucets needed replaced
- 5 sinks needed to be caulked

- 6 toilets needed to be replaced
- 23 toilets needed caulking

The Woodstock NH Environment Audit for Level One and Two A Side completed November 8 & 9, 2018, identified the following:
- all washroom floors needed strip and waxed
- all registers need to be painted
- all chair legs needed stained and varnished
- 11 room floors needed repaired and five to be replaced and two washroom floors to be replaced
- 33 rooms needed painted, 60 door frames and handles needed to be painted and 12 washroom walls to be painted
- four stained tiles to be replaced
- eight chipped vanities for repair
- four fixtures to be replaced
- 24 toilets required caulking

The Caressant Care Director of Operations (DOO) stated that the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form did not include monitoring to ensure that the home, furnishings and equipment were kept in good repair. The furnishings were not a part of the monitoring by the Environmental Services Supervisor (ESS) weekly. The DOO shared that the Woodstock Nursing Home (NH) Environment Audit was a summary of the results from the initial audits of resident rooms and common areas completed in November 2018. The findings were then entered into the online Maintenance Care (MC) system to monitor completion. The DOO produced a "Detail Report" from MC that cataloged routine daily, weekly, monthly, quarterly, annual and preventative maintenance tasks. The "Bathroom Renovations" schedule was reviewed and the DOO verified that 17 of 29 bathrooms on Level One B Side, North, South and East wing were completed.

The Caressant Care Woodstock Plan of Corrective Action for Inspection 2018_722630_019 documented that the Environmental Service Supervisor (ESS) was to develop a weekly monitoring process and fully implement to ensure that the homes furnishings and equipment were kept in good repair.

The "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form documented "Common Areas"; "Resident Rooms"; and "Safety." This

weekly checklist did not include monitoring to ensure that the home, furnishings and equipment were kept in good repair.

The Caressant Care Nursing & Retirement Homes Ltd. audit titled "Caressant Care Preventative Maintenance Program Resident's Rooms/Common Areas Quality Improvement Action Plan" last completed December 2018, documented specific items to be addressed in resident's rooms in each wing, but there was no documented inspection of common areas.

The Caressant Care (CC) Corporate Environmental Services Consultant (CESC) stated their role was to oversee all aspects of environmental services, primarily maintenance and housekeeping, as well as policy implementation and corporate contracts. The CESC said the daily running of the home was the responsibility of the ESS and Executive Director (ED). The CESC stated that a task list report was created from Maintenance Care to verify the completion and status of repairs daily, and the report was also used to prioritize the work daily. The CESC also stated that MC also tracked their ongoing routine preventative maintenance tasks which were automatically generated for completion. The CESC verified that the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form did not include monitoring to ensure that the home was clean and repaired and it was more of a safety check. The CESC stated that a complete bathroom refurbishing was being completed for all of Level One B Side, a full time painter was hired and the home was currently reviewing flooring costs for the entire home because the tiles were starting to crack and lift; and these interventions were being implemented to ensure areas of disrepair were being addressed. The CESC said the "Caressant Care Preventative Maintenance Program Resident's Rooms/Common Areas Quality Improvement Action Plan" was verified completed in December 2018, but the CESC stated some repair items were put on hold when the decision was made to replace the vanities and floors during the remodel of the Level One B Side bathrooms.

The Environmental Services Supervisor (ESS) stated they had worked for Caressant Care Woodstock since December 2018, as the designated lead for the housekeeping, laundry and maintenance service programs. The ESS explained the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form was used to monitor and document common areas, resident rooms and safety concerns in the home. The ESS verified this checklist did not satisfy a weekly monitoring process developed and fully implemented to ensure that the home,

furnishings and equipment were kept in good repair. The ESS also verified that although the checklist identified "Environmental Services/Maintenance person", the form did not include the staff responsible for monitoring. Other management staff members, including Sienna, also completed this checklist without identifying the staff member responsible for the monitoring each week it was completed. The ESS was asked how the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form satisfied CO #005 where the home was to ensure a weekly monitoring process was developed and implemented, including the staff responsible for monitoring, to ensure that the home was clean and repaired and the ESS replied that it did not, but the weekly housekeeping audit was developed to comply this. The ESS verified that the "Weekly Housekeeping Audit" did not include home areas of disrepair; only resident rooms had been monitored weekly. Inspector #563 and the ESS discussed the areas of disrepair observed in the home and the ESS stated that a total renovation was underway for all Level One B Side bathrooms. Each resident bathroom was planned to have a new toilet, new sink, new vanity, new flooring or repairs, wall repairs, new baseboards and a contracted painter was on site. The renovations and painting schedule was built into the online Maintenance Care schedules for routine, preventive and remedial maintenance.

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 the home and furnishings were maintained in good state of repair. The licensee also failed to comply with part e) of Compliance Order #005 from Inspection #2018_722630_0019, as the weekly monitoring process was not developed and fully implemented, including the staff responsible for monitoring, to ensure that the home, furnishings and equipment were kept in good repair. (563) [s. 15. (2) (c)]

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 related to a large number of residents. The home had a level 3 history as they had one or more non-compliances related to this section of the legislation that included:

- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued October 23, 2018 (2018_722630_0019). (563)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 30 (2).

Specifically the licensee must:

a) Ensure that for seven identified residents and any other resident who is dependent on staff for turning and repositioning, the repositioning interventions provided by staff are documented on each shift. This must include the documentation of any resident refusals of the repositioning care offered by staff.

b) Ensure that whenever an identified resident, or any other resident in the home, has an unwitnessed fall or has a fall during which they hit their head, the staff complete and document the Head Injury Routine (HIR) assessment as directed in the home's post fall management policy.

Grounds / Motifs :

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.

A) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a falls prevention and management program to reduce the incidence of falls and the risk of injury."

Ontario Regulation 79/10 s. 49 (2) states "Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls."

The home submitted a Critical System Incident (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC), on a specific date regarding a fall for an identified resident.

An incident progress note for this identified resident included details of the fall and stated that "a head injury routine (HIR) was initiated."

The home's policy titled “Safety Plan - Resident” with a reviewed date of May 2018, stated under section "Part C - Post Fall Management" "a) Initiate Head Injury Routine and assess the resident’s level of consciousness and any potential injury associated with the fall as required.”

During an interview a registered nursing staff said that after a resident had fallen the staff were expected to assess the resident and to do a head to toe, take vital signs, assess any injury for transfer to hospital and do a HIR for 72 hours if the fall was unwitnessed or if the resident hit their head. The staff member said they were not able to locate the HIR form in this resident’s paper chart.

Inspector #730 reviewed paper chart for this resident and was unable to locate the HIR form.

During an interview a Resident Care Coordinator said that the Head Injury Routine (HIR) was part of the home falls prevention and management policy. The RCC said that if a fall was unwitnessed then the staff were to do this or if it is witnessed and they hit their head the staff would need to complete.

During an interview the Director of Care (DOC) stated that they were not able to locate the HIR form for this resident. The DOC stated that it appeared that a HIR had been initiated per the progress notes for this resident, but they were not able to locate the documentation. When asked if it was in policy that a head injury routine

would be completed for this fall, the DOC replied yes.

The licensee has failed to ensure that any actions taken with respect to a resident under the falls prevention and management program, including assessments, were documented. (730)

B) Ontario Regulation 79/10 s. 48 (1) states "Every licensee of a long-term care home shall ensure that the following interdisciplinary programs are developed and implemented in the home: a skin and wound care program to promote skin integrity, prevent the development of wounds and pressure ulcers, and provide effective skin and wound care interventions."

Ontario Regulation 79/10 s. 50 (2) (d) states "Every licensee of a long-term care home shall ensure that 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."

Written Notification (WN) and Compliance Order (CO) #003 was issued October 23, 2018 during the Resident Quality Inspection (RQI) #2018_722630_0019 with a compliance due date of December 31, 2018. The licensee was ordered to comply with Ontario Regulation 79/10 s. 50 (2) (d). Specifically the licensee was order to ensure that: "a) Ensure that resident #006 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."

Based on observations and interviews the home was compliant with Ontario Regulation s.50 (2) (d) and completed step a) of CO #003. The licensee failed to complete step b).

Residents' clinical records were reviewed by Inspector #563 related to care skin care requirements for turning and repositioning every two hours. Based on this review seven residents were identified as needing to be repositioned by staff. The clinical record review showed all seven resident were at risk for skin breakdown and all

seven residents did not have the turning and repositioning task in Point Click Care for documentation prior to March 2019.

The Resident Care Coordinator (RCC) stated the Point of Care (POC) task for turning and repositioning was removed for all residents and the nursing team was now putting it back into POC for only those residents that required it. The RCC stated the Resident Assessment Instrument Coordinator (RAI-C) reviewed the kardex for all residents and for those residents who were limited, extensive or total assistance for bed mobility were care planned for turning and repositioning. The RCC stated that there should have been a POC task for all residents that required turning and repositioning. POC was the documentation system in place for the PSWs and the RCC shared there was no documentation in POC because there was no task in POC for the PSWs to document the turning and repositioning for those residents dependent of staff.

The Resident Instrument Assessment Coordinator (RAI-C) stated there was a management meeting to go over the findings from the RQI report and it was Sienna's recommendation to only have the turning and repositioning as part of the resident's care plan and kardex. The RAI-C was asked if the documentation of the repositioning care provided by staff was completed for all residents who were dependent on staff for repositioning and the RAI-C stated they were in the process of adding the turning and repositioning as a task for documentation in Point of Care for the PSWs.

The seven residents were observed by Inspector #563 and were turned and repositioned every two hours or more. Personal Support Workers provided assistance for transfers to and from bed, with toileting routines and with bed mobility. The residents were dependent on staff for repositioning and were repositioned every two hours or more.

The Registered Nurse (RN) and Skin and Wound Lead stated that it was the responsibility of the RAI Coordinators for adding and removing tasks in POC for a resident. The Skin and Wound Lead also shared that management had a meeting and the decision was to take the repositioning task out of POC. The repositioning task was only to be in the kardex and care plan and not added to any resident in POC for PSW documentation. The Skin and Wound Lead stated that the seven residents required staff participation for bed mobility with turning and repositioning every two hours and would not have had accurate and complete documentation of

the repositioning care provided by staff before March 2019.

The Sienna Senior Living Director of Operational Effectiveness (DOOE) stated that PSWs were required to document turning and repositioning in POC. The SSL DOOE was asked if they were aware that the POC task for turning and repositioning was removed from POC in December 2018 and they replied "no". Inspector #563 shared that the turning and repositioning task had only recently been added again for those residents who required turning and repositioning and the SSL DOOE stated they were not aware as there was a plan of action that it was to be done by the end of December to accurately reflect each residents needs as assessed.

Based on observations, staff interviews and review of clinical records, the licensee failed to ensure that any actions taken with respect to a resident under the Skin and Wound Program, the resident's responses to interventions were documented. The licensee also failed to comply with components of CO#003 from Inspection #2018_722630_0018, specifically related to the accurate and complete documentation of the repositioning care provided by staff to any resident who was dependent on staff for repositioning which had a compliance due date of December 31, 2018. (563) [s. 30. (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 3 as it related to a large number of residents. The home had a level 3 history as they had one or more non-compliances related to this sub-section of the legislation that included:

- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued October 23, 2018 (2018_722630_0019). (630)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 07, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 004

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

Linked to Existing Order / Lien vers ordre existant: 2018_722630_0019, CO #007;

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)(a).

Specifically the licensee must:

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

b) Develop, document and implement a process in the home for the leadership to evaluate, at least monthly, whether the written staffing plan is consistently meeting the residents' assessed care and safety needs in the

home. This evaluation must include:
i) an analysis of the care and safety needs of each group of residents in each section of the home which includes, but is not limited to, the residents' care needs related to Activities of Daily Living (ADLs) including toileting and continence care; responsive behaviours; assistance with transfers, mobility and positioning; skin and wound care; falls prevention; pain management; and medication administration.
ii) an analysis of whether the written staffing plan for each section of the home, as per the staff assignment sheet, is meeting the care and safety needs of all residents living in the home.
iii) a documented record of the evaluation which includes the date it was conducted, the names and signatures of the participants, the information analyzed, the results of the evaluation and what was done with the results of the evaluation.

c) Review and revise the job routines for each Registered Nurse (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW) position that is part of the written staffing plan, to ensure that the job routines are meeting the care and safety needs of the residents. A documented record of this review must be kept in the home and must include the dates conducted, the names and signatures of the participants, the results of the review and what changes were implemented as a result of the review.

d) Develop, document and implement a process in the home for the leadership to regularly audit staff response to resident callbells in each section of the home. A documented record of the audits must be kept in the home and include the date conducted, the names and signatures of the participants, the results of the audits and what was done with the results of the audits.

Grounds / Motifs :

1. The licensee has failed to ensure the written staffing plan required for the organized program of nursing services and the organized program of personal support services under clause 8 (1) (b) of the Act, provided for a staffing mix that was consistent with residents' assessed care and safety needs.

The licensee has failed to comply with Compliance Order (CO) #007 from Inspection

2018_722630_0019 served on October 23, 2018, with a compliance date of January 31, 2019.

The licensee was ordered to ensure that they were compliant with O.Reg 79/10 s 31. (3).

Specifically the licensee was ordered to:

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 backup 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.

The licensee completed step a).

The licensee failed to complete all components included in steps b), c), d) and e).

A) The Ministry of Health and Long-Term Care (MOHLTC) received complaint log #005055-19 which identified concerns with staffing and the care provided to their family member in the home.

During an interview with a family member for an identified resident they expressed concerns that they felt there was insufficient staffing in the home. The family member expressed specific concerns with the care provided to an identified resident.

The plan of care for this identified resident included specific interventions.

During the inspection, Inspector #630 observed that this identified resident was in a specific position at specific times which differed from the plan of care.

During an interview a staff member said that they would know what care a resident required from the kardex and through word of mouth. The staff member said that there were times when there were only two PSWs working in a specific area of the home and there was at times delayed response time to calbells and care requests. The staff member said at least three quarters of the residents in their area required a mechanical lift or sit to stand lift with two staff for transfers.

During an interview another staff member said they would look in the kardex to know what care a resident required. The staff member said it was difficult at times to provide the residents with the care they required. The staff member said they felt the staffing levels in the home were affecting care such as answering callbells in a timely way, toileting care, laying resident down and mouth care.

During an interview the Assistant Director of Care (ADOC) said that staff would know residents' care needs from the kardex and plan of care. The ADOC reviewed the plan of care and kardex for this resident and said that they needed specific care from staff. When asked if the staff in the home were able to provide this type of care consistently to residents, the ADOC said that residents had to wait at times as there were a lot of residents who required assistance.

B) During the inspection, Inspector #630 observed that an identified resident had activated their callbell related to needing continence care from staff. Based on this observation the resident waited at least nine minutes for continence care from staff.

During an interview this identified resident said they required assistance from staff with continence care and toileting. This resident said that they thought that usually the staff responded in a timely manner but sometimes they had to wait longer as the staff were busy.

During an interview a staff member said the expectation in the home was for staff to

answer the callbells as fast as they could. The staff member said there were times when they did not have full complement of staff or staff were on breaks when there were only two PSW staff for their area of the home and at those times residents had to wait for assistance from staff. The staff member said this identified resident required assistance from staff with continence care.

During an interview the Assistant Director of Care (ADOC) said it was the expectation that staff would respond to the callbells as soon as possible. When asked if they had identified any concerns with residents not receiving the continence care they required in the home, the ADOC said there had been some issues. The ADOC said if the PSWs were busy with one resident and then there was another callbell activated it could take 10 to 15 minutes to give care and would then be a delay in the response to the other resident. The ADOC said there had been times when they had to help with continence care and had called the registered staff to help with the toileting needs.

C) During an interview a registered nursing staff member told Inspector #689 that the expectation in the home was that a pain assessment would be completed when providing an as needed medication for pain to a resident. The registered nursing staff member said that they had received education on the pain assessment policy and found that they did not have enough time to do it all.

During the inspection, Inspector #630 observed that the callbell for another identified resident was activated and there were no staff in that area at the time. Based on this observation this resident waited at least 20 minutes for assistance from staff related to reported pain.

During an interview a registered nursing staff member told Inspector #689 that this resident had specific care concerns related to pain. They said this resident had reported pain on this specific shift.

Based on review of the clinical record by Inspector #689 there was no documented evidence that a pain assessment or pain monitoring was completed for this resident on the this specific shift.

During an interview a staff member said that it was challenging in that area to meet the care needs of the residents even when they were fully staffed and especially if

they did not have all five PSWs available. The staff member said that due to the care needs of the residents in that area related to responsive behaviours as well as the number requiring total care from staff. The staff member said that the staff felt overwhelmed and at times they would go home after their shift feeling badly and concerned they did not do enough for the residents. The staff member said that sometimes during peak hours for care, such as after meals, residents were having to wait 15 minutes for care from staff.

D) During the inspection, Inspector #630 observed that the callbell for resident another identified resident was activated. Based on this observation this resident waited at least 18 minutes for continence care from staff.

During the inspection on another day, Inspector #630 observed that there were three callbells activated in one area, including the one for this identified resident's room. Based on this observation this resident waited at least seven minutes for continence care from staff.

During the inspection on another day, Inspector #630 observed that the callbell for this resident's room was activated as well as for two other rooms in the area. Based on this observation this resident waited at least 15 minutes for continence care from staff.

The plan of care for this resident indicated that they required specific type of care from staff.

The staff member said they would know what care a resident required by the kardex and from knowing the residents in the home. The staff member said they were familiar with this identified resident. The staff member said that the staff were not always able to provide this resident with continence care in a timely as they were providing care to other residents in the area.

E) During the inspection, Inspector #630 arrived in a specific area and it was observed that the callbell for an identified resident was activated and there were no staff in the hallway. Based on this observation this resident waited at least 32 minutes for care from staff.

During an interview this resident told Inspector #563 that they had rung the bell for

assistance with toileting care and were waiting for assistance from staff. This resident said that they would have to wait for assistance with the bathroom and that they thought there were times when they had to wait over an hour for assistance. This resident said that there were times when staff did not assist them in time to prevent incontinence. This resident said they had no other concerns about the home other than they did not seem to have enough staff.

The plan of care for this resident included specific care interventions they required from staff for continence care.

During an interview a staff member told Inspector #630 that they would know what care residents required with continence care and toileting from the plan of care and from knowing the residents. When asked if residents had been receiving the assistance with toileting and continence care that they require in the home, the staff member said to the best that the staff were able but they needed more staff as residents were sometimes having to wait for care. When asked what the expectation was in the home in regards to responding to callbells, the staff member said they thought it was two minutes but sometimes they were with another resident and then another one was requesting assistance and they could not leave one unattended and sometimes that took time but they tried their best. The staff member said this resident required specific types of care from staff for continence care.

On another day during the inspection, Inspector #630 observed that the callbell for this identified resident was activated. The resident told Inspector #630 that they had rang their callbell and were waiting for assistance from staff to use the toilet. Based on this observation this resident waited at least 18 minutes for continence care from staff.

On another day during the inspection, Inspector #630 observed that the callbell for this resident was activated. Based on this observation this resident waited at least 18 minutes for continence care from staff.

F) During the inspection, Inspector #630 observed that the callbell for another identified resident was activated and there were no staff in the area as they were in other residents' rooms. Based on this observation this resident waited at least 21 minutes for care from staff.

During the inspection, Inspector #563 observed that the callbell for another identified resident was activated. Based on this observation, this identified resident waited at least 22 minutes for care from staff.

During an interview a staff member told Inspector #563 that on in that area there were only three PSWs to do everything on the day shift and that was not enough. The staff member said that the staff tried their best to give good care but there was not enough staff.

G) During the inspection, Inspector #630 arrived in a specific area and observed that an identified resident was in a specific position and had spilled a beverage on their lap and the floor. Based on this observation this resident waited at least 41 minutes for the care they required from staff.

During an interview a Resident Care Coordinator (RCC) told Inspector #630 that they were familiar with this resident and they were considered to be at risk for falls. The RCC said that this resident required specific assistance from staff.

The plan of care for this resident included specific interventions.

During the inspection Inspector #630 observed this identified resident in a specific position. During this observation the resident was provided a beverage by a staff member and the resident was observed to spill the beverage on their lap and the floor. Based on this observation this resident waited at least 27 minutes for the care they required from staff.

During an interview this staff member said they were familiar with this resident and they required specific care from staff. The staff member said staff tried their best to provide the care that this resident required. The staff member said that even when they were fully staffed with PSWs it was difficult to provide the residents with the care they required.

H) During the inspection, Inspector #630 observed another identified resident in their room verbally requesting staff assistance to use the washroom. A staff member went into the room and asked the resident to wait a few minutes as someone would be coming. Based on this observation this resident waited at least 15 minutes for continence care from staff.

During the inspection on another day, Inspector #630 observed this identified resident in their room with the callbell activated. Based on this observation this resident waited at least 23 minutes for continence care from staff.

The plan of care for this resident included specific interventions related to continence care.

During an interview with a staff member they said they were familiar with this identified resident and they required specific assistance from staff with continence care. This staff member said that sometimes this resident had to wait for assistance with toileting.

I) During the inspection, another identified resident's callbell was activated and the resident was yelling. A staff member was observed going to speak with the resident at a specific time and the resident asked them for a specific type of assistance and the staff member said they would get someone to help them. Based on this observation this resident waited at least 40 minutes for positioning and responsive behaviour care from staff.

The plan of care for this resident included specific interventions related to positioning and responsive behaviours.

J) During the inspection, Inspector #630 observed that the posted breakfast time in the Level One B Side dining room was 0800 hours. It was observed that staff and residents were still arriving in the dining room over 30 minutes after the posted breakfast time.

During the inspection, Inspector #630 observed that the posted lunch time for Level Two A Side was 1200 hours and there were no PSWs in the dining room to assist residents and 11 empty set spots at the tables. It was observed that staff and residents were still arriving in the dining room over 20 minutes after the posted breakfast time.

During an interview a staff member said that the breakfast meal was scheduled to start at 0800 hours. When asked if staff were consistently able to have residents ready for the breakfast meal by 0800 in the morning, the staff member said that not

in that area and usually residents and staff were getting there around 0830 hours. The staff member said that because of the care that they had to give residents each morning with dressing and toileting and cleaning and most of the residents required assistance from two staff it was difficult to get to the dining room in time.

During an interview the Nutrition Manager (NM) said the scheduled mealtimes in the home were 0800, 1200 and 1700 hours. When asked if staff were consistently able to have residents ready for the meals to be served at the scheduled times, the NM said no and they tried to be flexible with the meal service. NM #158 said that sometimes breakfast was not served until 0830 hours. The NM said this had an impact on the residents as it affected the amount of time that they had to eat their meals and they were more rushed and they could only hold the food for service for so long. The NM said that the PSWs were the ones bringing the residents into the dining room for the most part and a lot of times the staff were late.

K) During an interview a registered nursing staff member told Inspector #630 that the home had still been experiencing multiple shifts when they were working either part of full shifts without a full complement of staff. The staff member said that the home tended to use agency Registered Practical Nurses (RPNs) regularly. The staff member said that there were times when it was not possible for staff to get to residents as quickly or in a timely fashion.

During an interview with another registered staff member, they said that the Registered Nurses (RNs) in the home were responsible to ensure the residents were safe and stable, ensure medications done correctly, follow proper procedures, communicating changes of condition with the physicians and being in-charge of the floor and working as a team. The staff member said that after a resident had a fall they were responsible for assessing the resident and providing any required care. The staff member said that there were times when they did not have time during their shift to do all the documentation that was required related to falls assessment and they would stay after their shift to complete the documentation. The staff member said that they stayed after their shift on a regular basis. The staff member said there was a specific shift that they did not have time to complete the documentation for a post-fall assessment. The staff member said they tried their best to prioritize the care provided and to meet the needs of the residents but it was difficult especially when they were the only registered staff in the building on some night shifts.

During an interview a Resident Care Coordinator (RCC) reviewed the progress notes and acknowledged that there was no documentation of a post-fall assessment as per the expectation in the home for a specific resident on a specific shift. The RCC said they were not sure if this staffing issue had been discussed at the daily management meeting huddle.

L) During an interview the Executive Director (ED) told Inspector #630 that they had started working in the home in the ED position in January 2019. The ED said they were familiar with the CO #007 from Inspection #2018_722630_0019 and that the previous leadership in the home had been involved in working to comply the orders. The ED said that they had not personally been involved in reviewing the staffing plan as this had been done by the former Director of Care (DOC). The ED said that from their understanding the only change that was made to the staffing plan was the timing of shifts for the registered nursing staff. The ED said the leadership team in the home had been monitoring the shifts where there was not a full complement of staff working in the home and thought there had been improvements. When asked about the process for monitoring whether the staffing plan was meeting the care and safety needs of the residents, the ED said that point of care was monitored by the RAI Coordinators to ensure documentation was completed and the management all discussed staff shortages at the daily meetings.

During an interview a Resident Care Coordinator (RCC) said they were familiar with the CO #007 from Inspection #2018_722630_0019. The RCC said that the staffing plan in the home was the "Daily Staff Assignment" sheet in combination with the "Routine Staffing Plan." The RCC said they were not personally involved in the review of the staffing plan. The RCC said that they thought that the former DOC had reviewed the plan but they could not find a documented record of this review. The RCC said that there were changes made to the staffing back-up plan but there were no changes made to the routine staffing plan in the home.

During an interview the Caressant Care Director of Operations (DOO) told Inspector #630 that they had been the interim Executive Director (ED) in the home from September 2018 until the new ED was hired in January 2019. The DOO said they were familiar with the CO #007 from Inspection #2018_722630_0019. The DOO said that the staffing plan in the home was the "Daily Staff Assignment" sheet in combination with the "Routine Staffing Plan." The DOO said they were not personally involved in the evaluation of the staffing plan and that the former DOC and

Caressant Care Director of Quality and Privacy (DOQP) had been involved. When asked what was done to assess the residents care and safety needs to determine if the staffing plan was meeting those needs, the DOO said that they knew they had enough staffing with the staffing lines and the issue had been absenteeism. The DOO said they also did this through completing resident care audits. When asked to provide documented evidence of the resident care audits, the DOO said they were unable to locate documentation of the care audits. The DOO said that they had developed a process in the home to monitor and evaluate the staffing in the home as part of the "daily risk and leadership team huddle" and acknowledged that the form that had been developed had not been fully implemented. The DOO said that there were no changes made to the staffing plan as the RCC had done some work on changing the staffing lines and the staff routines for PSW but that had been stopped by the union in the home and was not implemented. When asked what was used to determine if the number of staff in each area of the home was meeting the care needs of the residents, the DOO said they thought that they looked at the Case Mix Index (CMI) but could not provide documented evidence that this had been included as part of the review. The DOO said they had provided a copy of the revised staffing back-up plan as a printed copy to all staff but they did not have documented evidence to show that all staff reviewed this plan. The DOO said there had been an improvement in the staffing levels in the homes in terms of vacant shifts. The DOO said that there had been a small increase in the use of agency RPNs in the home as the home was having trouble recruiting and they tried to get the same agency staff consistently.

The Caressant Care Director of Operations (DOO) provided Inspector #630 with the "Quality Program Evaluation Nursing and PSW Staffing Plan" dated October 30, 2018. This form did not include any trends or noted changes related to resident care or safety needs of staffing levels in each area of the home. This form also did not include any documented evidence that the staffing plan had been reviewed and revised to ensure it was meeting the care and safety needs of residents.

During an interview, the Sienna Senior Living Director of Operational Effectiveness (SSL DOE) told Inspector #630 that they were familiar with the CO #007 from Inspection #2018_722630_0019. The SSL DOE said that they were not personally involved in evaluating the staffing plan as that had been the Sienna Seniors Living Vice President of Operations. The SSL DOE said that they had provided samples of staffing plans and education to the past Executive Directors in the home on how to

develop staffing plans and contingency plans. When asked if they had been involved in monitoring whether the staffing plan was meeting the care and safety needs of the residents, the SSL DOE said that they had conversations with the management in the home about the care of residents during the management team meetings. The SSL DOE said that the staffing issues and variances in staffing levels was being discussed at the daily management meetings but was not sure if this was being documented in the home. The SSL DOE said the home did not have a way to monitor staff response to the callbells and the only way to do this was to watch and monitor and they were not sure if anyone in the home was monitoring this. When asked if they had identified any areas of care not being provided to residents based on their review of care in the home, the SSL DOE said they could not say specifically about care to residents but the documentation did not always meet the expectations and they had told the staff that assessments that were done but not documented then there was no way to prove that it was done. The SSL DOE said they had identified that there was documentation of pain assessments, skin and wound assessments and post fall assessments that had not been completed as per the expectations in the home. The SSL DOE said they thought that the staffing plan for the mix of registered staff was not a contributing factor to assessments not being completed and instead it was about holding staff accountable, ensuring staff were compliant and reviewing and revising things like staffing routine and the schedules for medication administration.

During a telephone interview the Sienna Seniors Living Vice President Operations (SSL VPO) told Inspector #630 that they were familiar with the CO #007 from Inspection #2018_722630_0019. The SSL VPO said that they had been involved in a collaborative effort to review the written staffing plan with the Sienna Seniors Living Director of Operational Effectiveness (DOE) and the Caressant Care Director of Operations (DOO) as well as the management working in the home. The SSL VPO said they initiated the process and they were involved in reviewing and evaluating the staffing plan but were unable to provide the specific date that they were involved. The SSL VPO said there were no changes made to the staffing plan as there was no need for changes. When asked how it was determined that no changes were needed, the SSL VPO said it was through conversations that it was determined that the status quo would remain. The SSL VPO said that since they had been working with the home Sienna had been connecting with the management in the home on a weekly basis and discussing staff vacancies, recruitment of staff as well as all areas of the operational business. The SSL VPO said they were not personally involved in

monitoring the care if the residents and they had provided the home with the management by walk about process. When asked if based on their opinion the staffing plan for the home was meeting the care and safety needs of resident, the SSL VPO said it was as the home had not utilized PSW agency staff and based on the weekly calls they had with the home.

The Sienna Seniors Living Vice President Operations (SSL VPO) provided Inspector #630 with a document titled "VP and Onsite Sienna team's contributions/recommendations to the following four areas as discussed with [Inspector #630] on March 19 2019." This document showed that on June 27, 2018, the staffing plan was reviewed. There was no other documented evidence that the staffing plan was review after the home was served Inspection #2018_722630_0019 on October 23, 2018. The document showed that on November 8, 2018, it was recommended that they home use the Sienna policy related to "suggested annual committee and program evaluation policy which includes staffing plans 31 (3)(e))." The document showed that on November 8, 2018, they reviewed the daily walk though and schedule and recommended the home "include the MOHLTC findings in current document for ongoing stability." There was no documented evidence that regular monitoring and recommendations were made by Sienna since January 31, 2019, related to the CO #007 requirement of weekly monitoring to ensure the written staffing plan was meeting the care and safety needs of the residents in the home.

During a follow-up interview, the Executive Director (ED) said the home was still actively recruiting for PSWs, RPNs and RNs to help ensure that there would be a full complement of staff in the home. When asked if based on their daily management meetings, huddles with staff and observations in the home if the current staffing plan was consistently meeting the care and safety needs of the residents, the ED said there were times when concerns were being brought forward and they would try to correct it immediately. The ED said that there were improvements that were needed especially with the PSW levels. The ED said the expectation in the home was that callbells would be responded to immediately and sometimes if staff were very busy giving care to other residents then it was the responsibility of the nursing staff and the management in the home to respond and say that someone would be there to address the request. Inspector #630 indicated that during the inspection resident had been observed waiting over ten minutes for care and asked if that met the expectations in the home, and the ED said that was not acceptable and that callbell response time had been identified as a concern during the walk troughs that had

been done by management in the home. The ED said that the callbell response time had been identified as a concern especially during the toileting time after breakfast as that was a time that the staff were busy. The ED said they hoped to improve the staffing plan to meet the needs of the residents in a timely manner and to build upon the improvements that had been made in the home.

Based on these observations, interviews and clinical record review the licensee has failed to ensure the written staffing plan required for the organized program of nursing services and personal support services provided for a staffing mix that was consistent with residents' assessed care and safety needs. The licensee has also failed to comply with CO #007 from Inspection 2018_722630_0019 served on October 23, 2018, with a compliance date of January 31, 2019. The home did not document and implement a process in the home for the leadership to monitor and evaluate, at least weekly, whether the written staffing plan was meeting the care and safety needs of the residents. The home did not complete a documented review of the written staffing plan, for routine staffing levels, to ensure it was meeting the care and safety needs of the residents and the staffing plan was not revised. The home did not provide documented evidence that all required staff had been trained on the revised staffing backup plan. (630) [s. 31. (3) (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 2 as it related to a pattern. The home had a level 4 history as they had one or more non-compliances related to this section of the legislation that included:

- Written Notification (WN), Compliance Order (CO) and Director's Referral (DR) issued October 23, 2018 (2018_722630_0019) with a compliance due date of January 31, 2019;
- 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 : Jul 31, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 005

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 49. (2)

Specifically the licensee must:

a) Ensure when two identified residents and any other resident has fallen that the resident is assessed by a registered nursing staff member.

b) Ensure that the home's Falls Prevention and Management program policies and procedures are complied with regarding the completion and documentation of post fall assessments for two identified residents, and any other resident who falls.

Grounds / Motifs :

1. The licensee has failed to ensure that when a resident had fallen, the resident was assessed and that where the condition or circumstances of the resident required, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls.

A) The home submitted a Critical Incident System (CIS) report to the Ministry of Health and Long-Term Care (MOHLTC) related to a fall for an identified resident.

During an interview a registered nursing staff member said it was the expectation in the home that after a resident had fallen that the registered staff would complete the

"Post Fall Investigation" paper form and initiate a "Risk Management" assessment in PointClickCare (PCC).

A progress note for this identified resident indicated that they had sustained a fall on a specific date at a specific time and sustained an injury.

The home's policy titled "CODE CARE: Come, Assess, Reach, Evaluate" with a review date of April, 2018, stated that when a resident had a fall, a CODE CARE would be paged by the staff member who discovered the incident. All staff from that care area were required to respond immediately. Point six of the procedure stated that the recorder completed the appropriate sections of the "Post Fall Investigation" form during the fall huddle.

During an interview with a staff member they had been working when this resident fell. The staff member said that the resident sustained an injury from the fall.

During an interview with another registered nursing staff member they said that this resident had a fall and sustained an injury on a specific date. The staff member provided a "Post Fall Investigation" form to Inspector #730 for this fall and said that the assessment was not completed. Inspector #730 asked the staff member if the "Risk Management" assessment had been completed in PCC for this fall and the staff member said they were not able to find one and one should have been initiated for that fall.

During an interview a Resident Care Coordinator (RCC) acknowledged that the "Post Fall Investigation" form for this resident was not completed after this fall as per the expectation of the home. (730)

B) During an interview a registered nursing staff member told Inspector #630 that after a resident had a fall the registered nursing staff were expected to complete a head to toe assessment, complete an incident report in risk management, do post fall documentation on each shift afterwards and follow-up with care for any injuries sustained from the fall. When asked if they consistently had time to complete these assessments, the staff member said that they did for the most part but there were times when they did not have time during their shift to do all the documentation and would stay after their shift was completed to do the documentation. The staff member said that another identified resident had sustained a fall on a specific date

and they had done a rapid assessment of the resident and the documentation they had completed for this fall was a progress note. The registered nursing staff member said that they had not completed the head to toe assessment, the risk management assessment or the paper post-fall assessment form as they did not have time on their shift. The staff member said they had been the only registered staff for the entire building for four hours of the night shift and they had to prioritize their time.

The clinical record for this resident included a progress note which documented the fall which had occurred on that specific shift and indicated there was a specific injury. The clinical record did not include a documented head to toe skin assessment, a post-fall assessment incident in risk management, a hard copy post-fall assessment form or a pain assessment.

During an interview a Resident Care Coordinator (RCC) said that based on the progress notes this resident had a fall on a specific date. The RCC reviewed the clinical record for this resident and acknowledged that there was no post fall documented on a paper form or in the computer documentation system. The RCC said they spoke with the registered nursing staff member who was working at the time of the fall and it was identified that the staff member did not have enough time to complete the required documentation. The RCC said it was the expectation in the home that post-fall assessments would be completed using the designated assessment forms.

Based on these interviews and record reviews the licensee has failed to ensure that when these two residents had fallen, the resident was assessed and that where the condition or circumstances of the resident require, a post-fall assessment was conducted using a clinically appropriate assessment instrument that was specifically designed for falls. (630) [s. 49. (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 related to 2 out of 4 residents reviewed. The home had a level 3 history as they had one or more related non-compliance with this section of the legislation that included:

- Written Notification (WN) and Voluntary Plan of Correction (VPC) issued January 18, 2018 (2018_606563_0001);
- WN and VPC issued June 17, 2017 (2017_605213_0007). (630)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : May 07, 2019

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 006

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

Linked to Existing Order / Lien vers ordre existant: 2018_722630_0019, CO #008;

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 home's pain management policy is reviewed and revised to ensure it provides clear direction on the procedures for how and when to monitor residents for pain and for monitoring the effectiveness of pain interventions. This review must include a review to ensure the policy provides clear direction regarding which monitoring tools are to be used for residents who are cognitively impaired. The home must keep a documented record of this review.

b) Ensure the home's pain management policy is reviewed and revised to ensure it provides clear direction on the procedures for how and when to assess residents for pain and the procedures for documenting the assessments using a clinically appropriate assessment instrument. The home must keep a documented record of this review.

c) Conduct a trial of the reviewed policy with four identified residents, and any other resident deemed appropriate, to ensure the revised policy provides clear direction for staff and meets the goals of the home's pain management program. The home must keep a record of the trial.

d) Ensure the Director of Care (DOC), Assistant Director of Care (ADOC), Resident Care Coordinators (RCCs), all RAI-Co-ordinators, all RPNs, RNs, including agency staff, are trained on the revised Pain Assessment Policy. The home must keep a documented record of the education provided including who provided the education, when it was provided and the materials that were covered during the education.

e) Ensure that each resident who has been identified as having pain has a plan of care in place which clearly identifies to staff which pain monitoring tool is to be used.

f) Develop and fully implement an auditing process to ensure the revised pain management policy is being complied with by staff in the home. This auditing process must be documented including the auditing schedule, the names of the staff conducting the audit, the residents who have been audited, the results of the audit, and what was done with the results of the audit.

g) Ensure the revised pain management policy is fully implemented to ensure that resident's pain is being monitored and 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 that 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.

The licensee has failed to comply with compliance order #008 from Resident Quality Inspection (RQI) #2018_722630_0019 served on October 23, 2018, with a compliance due date of December 31, 2018.

The licensee was ordered to ensure that they were compliant with O.Reg. 79/10, s. 52 (2).

Specifically the licensee was ordered to:

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 that 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 specifically designed for this purpose.

The licensee completed step a).

The licensee failed to complete steps b) and c).

The home's policy titled "Pain Management Program" with a reviewed date of February 2019, included the following under Procedures:
-"Each resident will be monitored for the presence of pain:
a) On admission, readmission, quarterly and annually by the RAI Coordinator only if triggered
b) With a new analgesic order, discontinuation of the analgesic or a change in dosage.
c) At times of significant resident condition change.
d) When a resident exhibits behaviours that may herald the on-set of pain.
e) A cognitive resident complains of pain 4 or greater
f) A resident exhibits changes in behaviour or facial grimacing.
g) A resident, family, staff or volunteer report pain is present."

-"Residents that have pain are to be treated in a step wise approach to non-pharmacological and pharmacological methods to control pain, maximize function and promote quality of life. The Interdisciplinary Team will develop the interventions. All interventions will be documented on the Resident's plan of care. Monitoring will be

completed utilizing the Numerical Pain Scale (cognitive, verbal residents) or the PAIN AD tool (non-verbal, cognitively impaired residents) located under the weights and vitals tab in PCC. Triggered assessments are completed using the Caressant Care Assessment Tool located under the Assessments tab in PCC."

-"The Registered staff will:
1. Screen for presence of pain and complete a pain assessment electronically:
-On move in and re-admission
-For RAI MDS scores of 2 or more
-When resident reports or exhibits signs and symptoms of pain (greater than 4/10 for 24-48 hours) following implementation of pharmacological and/or non-pharmacological interventions (i.e. satisfactory pain relief is not achieved following interventions)."

-"The monitoring periods for nursing are:
a) On readmission – every shift for 3 days.
b) On readmission from hospital – every shift for 3 days.
c) Significant change in status – every shift for 3 days or more as warranted by the resident's condition.
d) Initiation, Discontinuation or Dosage Change – every shift for 7 days (see Physician Notification criteria page 3).
e) As needed
f) On day 4 of the admission determine the resident's baseline and record it in PCC and/or care plan."

A) On a specific date, Personal Support Workers (PSWs) stated that a specific resident was identified as having pain symptoms and received pain management in the home.

On a specific date, a PSW told the inspector that they were familiar with the specific resident. The PSW stated that when a resident demonstrated pain or discomfort they would let the nurse know right away and that the nursing staff would complete pain monitoring and assessments.

The clinical record for the specific resident included documentation which showed that the resident had been provided pain medication on a specific date which was documented as ineffective. The clinical record also included documentation that the

resident had been hospitalized for a specific reason and then had returned to the home. There was also a progress note which indicated there had been a change in the resident's pain medications. There were no documented pain scales when the resident's pain medication was documented as ineffective; upon the resident's readmission from hospital; when the resident's pain medication was discontinued; or when the resident was assessed as having a significant change in status. There were no documented "Caressant Care Pain Assessment Tool" for the month of February 2019.

On a specific date, a Registered Nurse (RN) told the inspector that when a resident demonstrated pain or discomfort they would observe the resident for any signs and symptoms related to pain. The RN stated that they would complete a pain assessment identifying the resident's pain level on a scale of one through 10, or observe the resident if they were non-verbal and offer PRN medications if available. The RN stated that approximately one to two hours after completing the pain scale they would go back and check on the resident again to see if the interventions were managing their pain. The RN stated that they would use the "Numerical" pain scale for verbal residents and the "Pain Ad" for non-verbal residents, and the monitoring was documented under Weights and Vitals in PCC. When asked when staff should complete a pain assessment, the RN stated that the pain assessment would be done at the same time as the pain monitoring under the Assessments tab in PCC. The RN stated that they were familiar with the specific resident who was able to verbalize their pain and had infrequent pain. When asked how the residents' pain was monitored, the RN stated that the resident came back from the hospital and was monitored daily by asking them about their pain, but they did not feel it was necessary to complete the pain monitoring because there was no change that required staff to complete the monitoring tool on PCC.

On a specific date, the Assistant Director of Care (ADOC) stated that the specific resident was able to verbalize pain and had interventions of pain medications to be implemented when the resident exhibited pain. The inspector and the ADOC reviewed the clinical record for the resident and the ADOC acknowledged that the pain medication provided as needed was documented as ineffective. The ADOC stated when analgesic medications were not effective, it was expected that the staff start the flow sheets for pain monitoring and complete a pain assessment. When asked what the expectation was per the home's pain policy for staff to assess and monitor the effectiveness of a medication change, the ADOC stated that they were to

monitor the resident for seven days and document using the pain scales under Weights and Vitals in PCC. The inspector and the ADOC reviewed the clinical record for the resident for a specific date and the ADOC acknowledged that the residents' pain medication was discontinued on a specific date. The ADOC confirmed that there were no pain scales or pain assessments completed on that date. When asked if they would expect that a pain scale had been completed for the resident to monitor pain when their pain medication was discontinued, the ADOC stated yes. The inspector and the ADOC reviewed the residents' clinical records in PCC and the ADOC acknowledged that the resident was transferred to hospital on a specific date, was readmitted to the home on a specific date, and had a significant change in status assessment completed on a specific date. The ADOC stated that there was no pain monitoring or pain assessments completed in PCC upon the residents readmission or when the resident had a significant change in status. When asked if they would expect as per the home's pain policy that a pain assessment had been completed to re-assess the resident's pain at the time of readmission and when there was a significant change in status, the ADOC stated yes. When asked if they would expect that a clinical assessment was used to assess the resident's pain when initial interventions were not effective, the ADOC stated yes.

B) On a specific date, Personal Support Workers (PSWs) stated that another specific resident was identified as having pain symptoms and received pain management in the home.

On a specific date, the PSW stated that they were familiar with the specific resident. The PSW stated that the resident was not able to verbalize their pain or discomfort, but staff would observe their facial grimacing. The PSW stated that the resident's pain interventions included that staff were to document and report complaints of pain.

The clinical record for the specific resident indicated there had been a change in the resident's pain medications. There was a progress note on a specific date which documented that the resident was showing signs of pain. There were no documented monitoring scales and no documented "Caressant Care Pain Assessment Tool" for a specific time frame.

On a specific date, a RN told Inspector #689 that PSW's would monitor the residents' for pain while providing care and would let the nursing staff know. When asked when

staff would complete a pain assessment, the RN stated that the pain assessment would be done at the same time as the pain monitoring under the Assessments tab in PCC. The RN stated that they were familiar with the resident and they were not able to verbalize pain or discomfort and would observe the resident for signs to identify if they had pain. The RN stated that they did not monitor the resident all the time, but would ask the PSWs if the resident looked uncomfortable. The RN stated that a pain assessment would be completed for the resident if they were seen to be uncomfortable or grimacing, not just on one shift, but if pain was observed consistently. When asked how a resident was assessed for pain when determining the effectiveness of discontinuing pain medications and if a pain assessment should be completed, the RN stated that if a pain medication was not needed anymore then staff should monitor the resident's pain, observe the resident and make a progress note on each shift, but that they would not do a pain assessment. When asked how staff would know whether or not the pain medication change was effective if staff did not complete a pain assessment, the RN stated that this would be identified through the monitoring of the resident. Inspector #689 and the RN reviewed the clinical records for the resident and identified that the resident's pain medication was discontinued on a specific date. When asked if the resident's pain was monitored after the discontinuation of their pain medication on a specific date, the RN confirmed that there was no documented pain monitoring. When asked how staff would know if the discontinuation of the medication was effective in managing the resident's pain if there were no documented monitoring, the RN stated that monitoring of pain should have happened. The RN confirmed that there were no pain assessments documented in PCC for the resident.

On a specific date, the ADOC stated that the resident was sometimes able to verbalize pain and discomfort and had pharmacological interventions to be implemented when the resident exhibited pain. The ADOC reviewed the residents' clinical records and confirmed that no pain monitoring was documented for the resident when their pain medication was increased or when their routine pain medication was discontinued. When asked what the expectation was for monitoring a resident for pain after discontinuation of a pain medication, the ADOC stated that they should be monitored for seven days. The ADOC stated that they would expect that a pain assessment had been completed for the resident at the time their medications were discontinued to assess the effectiveness of the interventions. The ADOC stated that the last pain assessment completed for the resident was on a specific date, and confirmed no pain assessments were documented in PCC before

this date.

C) On a specific date, a Personal Support Workers (PSWs) stated that another specific resident was identified as having pain symptoms and received pain management in the home.

The clinical record for the specific resident indicated this resident had been requesting pain medication from staff. There was a progress note on a specific date which documented that the resident was showing signs of pain. There were no documented monitoring scales and no documented "Caressant Care Pain Assessment Tool" for a specific time frame.

On a specific date, a Registered Practical Nurse (RPN) stated they were familiar with the resident. The RPN stated that the resident was able to verbalize their pain and would complain of pain in a specific area. The RPN stated that the resident received specific pain medications and their pain was monitored and documented using the pain scales. When asked what tools would be used to assess a resident's pain level if they were unable to communicate verbally, the RPN stated they would use the Pain Ad scale. Inspector #689 and the RPN reviewed the resident's progress note on a specific date which showed that the resident was provided breakthrough pain medication, but their pain was unable to be rated on pain scale. The RPN stated that they had documented and provided the medication to the resident on this date. When asked how they knew to provide the medication as an intervention if they did not assess the resident's pain level, the RPN stated that the resident complained of pain and then the medication was provided. When asked if it was required that a pain scale should be completed prior to providing a pain medication, the RPN stated yes. The RPN stated they would need to complete the pain scale to know what intervention to use. The RPN stated that if a resident had no relief from initial interventions they would expect that a clinically appropriate pain assessment had been completed.

On a specific date, the ADOC stated that the resident had pharmacological interventions to be implemented when the resident exhibited pain, and was sometimes able to verbalize pain. Inspector #689 and the ADOC reviewed the resident's progress note on a specific date which stated that the resident was provided pain medications as needed and that the resident was unable to rate the pain on pain scale. The ADOC stated that the expectation was that if the resident

was unable to rate their pain, the Pain Ad scale should have been used. The ADOC reviewed the clinical records in PCC and confirmed that no pain monitoring or pain assessment was completed for the resident on a specific date. When asked if initial interventions were not effective, would they expect that the resident had been assessed using a clinically appropriate tool related to effectiveness of interventions, the ADOC stated yes. The ADOC stated that when the resident expressed no relief from pain then the residents' pain was not relieved by initial interventions and they should have had a pain assessment completed.

D) On a specific date, Inspector #630 observed that a specific resident had activated their call bell. The resident had stated to the inspector that they had a lot of pain in a specific area. When asked by the inspector what had been provided to them for pain the resident stated that they had been given a pain pill, but it was not working. The inspector observed a Registered Practical Nurse (RPN) arrive at the residents' room and the resident told the RPN that they had pain. The RPN asked the resident what type of pain they had and to score it. The RPN stated to the resident that they would ask another staff to come and assist them.

On a specific date, a RPN told Inspector #689 that they were familiar with the resident. When asked if the resident was able to verbalize their pain, the RPN stated yes the resident was able to express pain, was very aware of their pain and was able to talk about it. When asked what was done to manage the residents pain, the RPN stated that the resident had received a specific pain medication at a specific time, another pain medication at a specific time.

The clinical record for the specific resident indicated this resident had been requesting pain medication from staff and had changes made to their pain medication orders. There was a progress note on a specific date which documented that the resident was showing signs of pain. There were no documented monitoring scales and no documented "Caressant Care Pain Assessment Tool" for a specific time frame.

On a specific date, the ADOC stated that the resident was able to verbalize their pain. The ADOC stated that even after the resident was provided pain medications they would still have pain. The ADOC stated that the resident had been visited by the pain consultant and had an increase in their pain medications. When asked if the resident was exhibiting pain even with the change in medication, the ADOC stated

yes. The Inspector and the ADOC reviewed the residents' eMAR on specific dates which documented an increase in the resident's pain medications. The ADOC confirmed that there was no documented pain assessments completed on the dates the pain medication was changed. Inspector #689 and the ADOC reviewed the residents' clinical records which showed documentation that the resident was consistently expressing pain, often greater than four out of 10. When asked how long pain monitoring should be completed when a resident exhibited pain as four or greater, the ADOC stated that if a medication was provided and pain was greater than four out of 10, then pain monitoring was to continue using the pain scales. The ADOC stated the expectation would be that the resident should receive constant monitoring and staff should inform the physician. The ADOC stated that staff should be completing a pain assessment for when the resident complained of pain greater than four out of 10 for 24 to 48 hours as per the policy and confirmed this was not being completed.

E) On a specific date, a Registered Practical Nurse (RPN) stated that they were working in the home pursuant to a contract as an agency staff member. When asked when they would complete a pain assessment on a resident, the RPN stated on admission, and monthly or quarterly as per the policy, and this would be documented under the Assessments section in Point Click Care (PCC). When asked if they had received training in the home on the pain assessment policy, the RPN stated no.

On a specific date, the Assistant Director of Care (ADOC) stated that their role related to CO #008, was that they provided the pain management education in the home on the revised pain policy. The ADOC reviewed the home's pain policy titled "Pain Management Program" with a reviewed date February 2019, which stated "the registered staff will screen for presence of pain and complete a pain assessment electronically". The ADOC stated that according to the policy, a pain assessment should be completed on move in or readmission, including return from hospital; for a RAI MDS score of 2 or more; or when a resident reported pain greater than 4 within 24 or 48 hours following interventions. The ADOC stated that staff were required to do a pain assessment after being provided a pain medication. The ADOC stated that if the pain assessment was not satisfactory, pain monitoring would be completed through one of three options: pain scales under Weights and Vitals in Point Click Care (PCC), the pain management flow sheet (PMFS), or a pain progress note in PCC. No PMFS records were provided to the inspector for these residents during the course of the inspection. When asked when pain monitoring was expected to be

completed for a resident, the ADOC stated that there were six criteria as per the policy which provided time frames for how long to monitor the resident for pain. The ADOC referred to the revised pain policy which stated "the monitoring periods for nursing are" and read the following: on readmission – every shift for 3 days; on readmission from hospital – every shift for 3 days; significant change in status – every shift for 3 days or more as warranted by the resident's condition; initiation, discontinuation or dosage change – every shift for 7 days (see physician notification criteria page 3); PRN; and on day 4 of the admission to determine the resident's baseline and record it in PCC and/or care plan. The Inspector reviewed the pain policy with the ADOC and inquired about the monitoring for the presence of pain as per the policy for the following: when a resident exhibited behaviours that may herald the on-set of pain; for when a cognitive resident complained of pain 4 or greater; when a resident exhibited changes in behaviour of facial grimacing and when a resident family, staff or volunteer reported pain was present, and asked the ADOC to explain the monitoring periods for these instances. The ADOC stated that for those instances a resident would be monitored as a "significant change in status" as listed in the policy, which stated every shift for three days.

On a specific date, Caressant Care Director of Clinical Services and Education (DCSE) stated that their role related to CO #008 was that they were part of the pain committee and reviewed and revised the home's pain assessment policy. The DCSE stated that on December 17, 2018, they and Caressant Care Regional Director of Operations (RDO) provided education to the managers on the revised and final draft of the pain policy. When asked if the policy revisions changed or altered the pain management process in the home, the DCSE stated yes. Inspector #689 asked how they knew how long to complete a pain assessment for when a resident exhibited behaviours, if a cognitive resident complained of pain 4 or greater, or if a resident, family, staff or volunteer reported pain was present, as this was not documented in the policy. The DSCE stated that it was not provided in the pain policy, but on the pain algorithm. When asked how staff would know when to complete pain monitoring, the DSCE stated that when a resident complained of pain, then a pain assessment would be completed and was their understanding that staff were to use the pain scales only when an analgesic was provided.

On a specific date, the DCSE informed Inspector #689 that the Regional Director of Operations (RDO) could clarify information provided during their previous interview. The RDO stated that role related to CO #008 was that they were part of the pain

committee and reviewed and revised the home's pain assessment policy. The inspector asked what the expectation was for monitoring and what tools should be used as per the policy, the RDO stated that according to the policy, the monitoring of pain was completed using the pain scales under weights and vitals in PCC, and the flow sheets were used as an additional tool to manage and monitor administration of pain medications. When asked what the expectation was for staff to complete a clinically appropriate assessment for pain, the RDO referenced the Pain Management Policy which stated "the monitoring periods for nursing are" and stated that staff were to complete a pain assessment under the Assessments tab in PCC for the following periods: on readmission – every shift for 3 days; on readmission from hospital – every shift for 3 days; significant change in status – every shift for 3 days or more as warranted by the resident's condition; Initiation, Discontinuation or Dosage Change – every shift for 7 days; PRN; or on day 4 of the admission to determine the resident's baseline. When asked if the heading "monitoring periods" in the policy was referencing when to complete a pain assessment under PCC, then how would staff know how long to monitor pain using the pain scales, the RDO stated that this information was not provided in the policy.

F) The licensee was ordered to ensure that they were compliant with s. 52 (2) of the Long-Term Care Homes Act (LTCHA), 2007, with a compliance due date of December 31, 2018. Specifically the licensee was ordered to:

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.

On a specific date, the Assistant Director of Care (ADOC) stated that their role related to part b) of CO #008 was that they provided staff with the pain management education on the revised pain policy. The ADOC stated that they provided one to one education for the staff on December 20, 27, 28, and 31, 2018. The ADOC reviewed the documented records maintained by the home of the education provided on the revised pain assessment policy, and stated that the names identified on the document titled "List of TLC Agency Staff That Need Pain Management Education" were agency staff who needed education. The ADOC stated that the check marks identified beside the names were the agency staff who received education with the Resident Care Coordinator (RCC). The ADOC confirmed that no education was

provided to the agency staff until February 22, 2019.

Review of the home's documented education record titled "List of TLC Agency Staff That Need Pain Management Education" showed the following:
- 4 out of 9 (44 per cent) agency staff signed and dated that they had received the education on February 22, 2019.
- 9 out of 9 (100 per cent) of agency staff did not receive education prior to the compliance due date of December 31, 2018.

Based on clinical record reviews, policy review, interviews and observations, the licensee has failed to ensure that the home's revised "Pain Management Program" policy was complied with in order to ensure that when specific resident's pain was not relieved by initial interventions, the residents were assessed using a clinically appropriate assessment instrument specifically designed for this purpose. (689) [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 4 out of 4 residents. The home had a level 3 history as they had one or more non-compliances related to this section of the legislation that included:

- Written Notification (WN) and Compliance Order (CO) issued October 23, 2018 (2018_722630_0019) with a compliance due date of December 31, 2018. (689)

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 007

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

Linked to Existing Order / Lien vers ordre existant: 2018_722630_0019, CO #004;

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 :

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

The licensee 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 home is kept clean and sanitary. This must include, but is not limited to, the floors, carpets, furnishings, privacy curtains, contact surfaces and wall surfaces, in resident bedrooms, common resident areas and staff areas.

b) Ensure that procedures are developed and implemented in the home to ensure the cleaning and disinfection of assistive aids and positioning aids in resident bathrooms.

Grounds / Motifs :

1. The licensee has failed to ensure that as part of the organized program of housekeeping under clause 15 (1) (a) of the Act, 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.

The licensee has failed to comply with compliance order #004 from Resident Quality Inspection (RQI) #2018_722630_0019 served on October 23, 2018, with a compliance due date of December 31, 2018.

The licensee was ordered to ensure that they were compliant with O Reg. 79/10 s. 87 (2).

Specifically the licensee was ordered to:

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.

The licensee completed step b). The licensee failed to complete steps a) and c).

Inspector #563 observed the home areas for clean and sanitary conditions. The following was identified:

Level One B Side Hallway:
- Baseboard in the hallway at the intersection near the East nursing station was missing, with a build-up of dirt and debris.

Whirlpool Room on Level One B Side:
- Shower stall next to closet where grout was stained yellow brown in colour along the lower tiled walls on either side.

Level One B Side (North, South and East Wings):
- Dust build-up noted in multiple wall grates.
- Multiple resident rooms where the floor perimeter around the door frames and room had a build-up of dust, dirt and debris. Baseboards near the bottom of resident doors were peeled off and dust and dirt had accumulated.
- Brick wall along the hallway behind the double doors near the B dining room had a build-up of dirt and debris along the perimeter of the floor and in between the brick.
- Build-up of what appeared to be sand outside one resident room in East wing and located in the right corner of the door frame.
- Multiple resident bathrooms had a build-up of a white hardened substance on the faucets, a dark brown build-up between the floor tiles, a build-up of dirt around the base of toilets, brown wall splatter behind one toilet, dust with a black residue and hair noted along the assist bars connected at the back of toilet seats, a build-up of dust, hair, webs, dirt and debris along floor perimeter and under bathroom sink counters and cobwebs behind resident toilets. Water valves behind toilets were covered in dust and webs.
- A resident stated that they saw “little black bugs near the toilet” and pointed to the

counter on the floor. Small black round particles were noted in this area.

The Caressant Care (CC) Director of Operations (DOO) stated that the weekly monitoring process was developed and partially implemented because it was completed for each week in November, but not at all for December 2018, only the first week of January 2019 and nothing for February 2019. The DOO provided a "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form dated in January 2019 and stated this was the only weekly checklist completed that they could find. The DOO also explained that they completed a Monthly Housekeeping Audit of all resident rooms in the home. The audit documentation identified areas that needed cleaned, painted, repaired or replaced. The CC Director of Quality and Privacy was also present during the interview.

Inspector #563 showed the DOO and the CC Regional Director photographs taken of the build-up of dirt, dust, debris and cobwebs. The DOO verified that the procedures developed to ensure the home was clean and sanitary were not implemented.

The "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form documented the following: "Common Areas"; "Resident Rooms"; and "Safety." This weekly checklist did not include monitoring to ensure that the home, furnishings, equipment were kept clean and sanitary.

The Director of Operations (DOO) verified it was the expectation of the home that all resident rooms, including floors, bathrooms floors, toilets, sinks, mirrors and counters be cleaned daily by the housekeeping staff and twice a week there was a deep clean of two resident rooms in each home area. The vents were not documented as part of the audits and checklists completed by the Environmental Services Supervisor (ESS) and DOO stated this was a monthly routine task built in maintenance care for the exhaust fans, but it was not closed as completed for February 2019. The DOO shared that it was documented as "NEW" in maintenance care when it still required completion and would change to "CLOSED" when the task was done. The exhaust fans were still documented as "NEW". The DOO also stated that a "Weekly Walk – Thorough Checklist" was to be done daily by the Executive Director "ED", "Maintenance person", "Activation", "Dietary", and the Director of Nursing "DON" and it was the responsibility of the person doing the checklist to be keep them. The DOO verified that the daily walkabouts and documentation was completed for one week in January 2019, by the ED with nothing further. The DOO also verified that the

"Weekly Walk – Through Checklist Environmental Services/Maintenance person" form did not include monitoring to ensure that the home, furnishings and equipment were kept clean and sanitary and the checklist did not identify who completed the audit.

The DOO provided Inspector #563 with copies of the following documents:
- "Weekly Walk – Through Checklist for Environmental Services/Maintenance person" completed the week of January 7 and February 27, 2019;
- "Weekly Walk – Through Checklist – Management" completed the week of January 21, January 28, February 4, 2019;
- "Weekly Walk – Through Checklist – Executive Director" completed the week of December 31, 2018.

Inspector #563 made additional observations of B side. The following was identified:

Level One B Side (North, South and East Wings):
- Multiple resident rooms where the floor perimeter behind resident doors, around the door frames and room had a build-up of dust, dirt and debris.
- Brick wall along the hallway behind the double doors near the B dining room had a build-up of dirt and debris along the perimeter of the floor and in between the brick.
- Build-up of what appeared to be sand, hair and dust outside one resident room in East wing and located in the right corner of the door frame still present since February 25, 2019.
- Multiple resident bathrooms had a build-up of a white hardened substance on the faucets, a dark brown build-up between the floor tiles, a build-up of dirt around the base of toilets, brown wall splatter behind one toilet, dust with a black residue and hair noted along the assist bars connected at the back of toilet seats, a build-up of dust, hair, webs, dirt and debris along floor perimeter and under bathroom sink counters and cobwebs behind resident toilets. Water valves behind toilets were covered in dust and webs.
- A resident bathroom had yellow dried build-up at base of toilet and around bolt caps, floor perimeter had build-up of dark black brown debris and dirt, and far corner floor under the sink near doorway with a build-up of hair, dust and debris.
- Wall ventilation near "kitchen" door in the South wing build-up of dust observed.

The housekeeper stated the cleaning of resident washrooms included sweeping the floor, cleaning the mirror, wall spot cleaning, dusting, cleaning the toilet, emptying the

garbage and washing the floor every day. The resident rooms included dust mopping the floor, and if night stands and wardrobes needed dusting. A total room cleaning, on average, would occur every three months where all furniture would be moved out from the walls and corners would be dusted for cobwebs, along the window curtain rods, the entire room floor would be dust mopped, the bed frame, mattress and headboard would be washed, then the floors washed, and window ledges, lights and furniture wiped. The Housekeeper explained that they would have to use a "scrubby" to remove the ground in dirt around resident doorways and door frames. The wall vents were to be cleaned by the maintenance staff, but housekeeping would also wipe them off for dust. The housekeeper also verified that there should not be an accumulation of cobwebs, dust, debris and dirt behind toilets and under sink cabinets if the floors were cleaned daily. They said for the dark black/brown build-up at the corners where the lid was connected or the assist bars were connected to the toilet basins on B side, the housekeeping should be notifying maintenance to remove the assistive device so that the area could be cleaned.

The Caressant Care Corporate Environmental Services Consultant (CESC) stated that the home was to complete a housekeeping audit monthly for general observations of four resident rooms and it was the responsibility of the Environmental Service Supervisor (ESS) and the Executive Director to follow up to ensure the housekeeping expectations were being met. The purpose of this audit was to review four resident rooms per wing because the home have different housekeepers doing different sections. The ESS would then review the documentation and look for trends. The audit would then be calculated where a higher percentage would indicate that housekeeping tasks were being performed and completed for the items listed as part of the audit. Inspector #563 shared that multiple resident bathrooms on B side were observed for a dark brown build-up between floor tiles around toilets. The CESC stated that the housekeeping staff were to use a steam cleaner if they had one. The CESC shared that a steam cleaner was being ordered "today", but that all the floors on B side were being replaced in the washrooms. The CESC also stated that new counters were being installed in all B side bathrooms and the old cabinets removed. The flooring would go straight back to the wall so that those edges were cobwebs, dust, debris and dirt accumulated under sink cabinets would be eliminated. Also, part of the bathroom refurbishing was to install the wall mounted grab bars. The CESC stated this would eliminate the need for assist bars to be mounted to the basin on the toilet where dark black/brown build-up was observed. The ground in dirt around resident doorways, baseboards and door frames require a steamer to remove

the build-up, but that the floors should be mopped every day with a microfiber system. The CESC verified that the "Weekly Walk – Through Checklist Environmental Services/Maintenance person" form was a safety check and the home, furnishings, and positioning aids were not monitored for cleanliness using that form. The CESC was asked what weekly monitoring process was developed and implemented to ensure the home was clean and repaired and the CESC replied the home created a "Weekly Housekeeping Audit" from the "Monthly Housekeeping Audit " already in use.

The Caressant Care Nursing & Retirement Homes Ltd. policy titled "Housekeeping Audit" last reviewed September, 2018, stated, "The housekeeping audit shall be completed on a monthly basis to ensure resident rooms meet the Housekeeping standards of the facility and of the Ministry of Health and Long Term Care." The procedures in this policy stated, "Complete the forms as follows: choose 4 rooms at random to be inspected; inspect the room as per the log checklist and identify any deficiencies; total all checklist boxes and all positive outcomes to determine a percentage; monitor and evaluate the percentage month over month noting any trends; and 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 Environmental Services Supervisor (ESS) stated they had worked for Caressant Care Woodstock since December 2018, as the designated lead for the housekeeping, laundry and maintenance service programs. The ESS stated that there were routines that housekeeping followed to ensure the home was clean and sanitary that included a deep cleaning schedule and daily cleaning guidelines for resident rooms and common areas and the tub rooms. There was also an A1, A2 and B Shift Housekeeping Routine and a Student Housekeeping Job Routine. The ESS stated the expectation for cleaning resident rooms, including floors and bathrooms was daily. Cleaning included anything that can be easily reached by the housekeeping staff, including wall intake vents. The ESS shared that walk-throughs and checklists were completed home to ensure the furnishings and equipment were kept clean and sanitary. The ESS also shared that the "Weekly Housekeeping Audit" was created to comply both CO #004 and CO #005 from Inspection 2018_722630_0019 related to weekly monitoring. The ESS completed this form weekly until they were off work for approximately three weeks and verified that it did not include the clean and sanitary conditions of the home and furnishings. The

"Weekly Walk – Through Checklist Environmental Services/Maintenance person" form did not include the staff responsible for monitoring. The form did not identify the person completing the audit.

Inspector #563 made additional observations regarding the cleanliness of the home. The following was identified:

Level One B Side (North, South and East Wings):
- Multiple resident rooms where the floor perimeter behind resident doors, around the door frames and room had a build-up of dust, dirt and debris.
- Brick wall along the hallway behind the double doors near the B dining room had a build-up of dirt and debris along the perimeter of the floor and in between the brick.
- Resident bathroom toilet where assist rails connected to the back basin had a build-up of greenish yellow and brown fluid and dust along the entire device, and the floor along perimeter of the toilet had dark brown black build-up along toilet and between floor tiles with brown yellow staining, bathroom baseboard peeled from the wall with wall damage and peeling paint and build-up of dirt and dust at the corner
- East hall: build-up of dust along upper edge of baseboards along entire hallway, both sides and small area of wall near the double doors was bricked and painted white with a build-up of dust, dirt and debris along the perimeter.
- Wall vent near E29 still covered in dust.
- Baseboards chipped and peeling at corner edge with dried paint on top of old dust and dirt on the floor.

Level One and Two A:
- Near room A221, a water cooler was observed with a build-up of dust and dirt behind the water cooler and the floor was marked with brown streaks and a build-up of a dark brown substance between the floor tiles.

"Global" Fans:
- Wall mounted rotating fan near room E5 was covered in layered dust and hair on the entire steel cage and fan blades.
- Wall mounted rotating fan near room N31 was covered in layered dust and hair on the entire steel cage and fan blades.

The Sienna Senior Living (SSL) Director of Operational Effectiveness (DOOE) stated Sienna recommended housekeepers to be assigned to one floor for consistency and

to get to know the residents and the floor by using a primary care model to develop a stronger housekeeping ethic. Inspector #563 asked what weekly monitoring process was developed to ensure the home, furnishings and equipment was kept clean and sanitary and the SSL DOOE replied that each manager completed a full daily walk around and made recommendations. Inspector #563 provided a document completed by the SSL DOOE one day in February 2019 titled the "Weekly Walk-Through Checklist – Environmental Services/Maintenance Person" and the SSL DOOE verified that the checklist appeared to be general and did not include the monitoring of the clean and sanitary conditions of the home and furnishings. The SSL DOOE then stated that there was also a "Weekly Walk-Through Checklist – Management" tool used and again verified that it too did not include the monitoring of the clean and sanitary conditions of the home and furnishings. The SSL DOOE "Weekly Walk-Through Checklist – Management" tool included "is furniture free of rips and stains" but that this was disrepair, not cleanliness. Inspector #563 provided a document titled, "Weekly Housekeeping Audit" completed by the SSL DOOE once in February 2019 and they verified that it was the tool developed and used to ensure compliance with CO #004 related to housekeeping. The SSL DOOE also verified that the "Weekly Housekeeping Audit" only included resident rooms and not the home and furnishings in common areas. The SSL DOOE also verified that the "Weekly Walk-Through Checklist – Management" did not include the staff responsible for monitoring and stated that "management" could mean the Resident Care Coordinator, Assistant Director of Care, Director of Care or the Executive Director and acknowledged that the completed forms did not identify the staff member who completed the audit.

Based on observations, staff interviews and record review of policies and procedures related to the housekeeping of resident rooms and common areas, the licensee failed to ensure that procedures were developed and implemented for cleaning of the home, resident bedrooms, and common areas; and the cleaning and disinfection of assistive aids and positioning aids used in the resident washrooms. The licensee also failed to comply with Compliance Order #004, as they failed to ensure a weekly monitoring process was developed and implemented, including the staff responsible for monitoring, to ensure that the home, furnishings, equipment and residents' assistive aids and positioning aids were kept clean and sanitary with a compliance due date of December 31, 2018. (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 related to a pattern. The home had a level 3 history as they had one or more non-compliances related to this section of the legislation that included:

- Written Notification (WN), Compliance Order (CO) issued October 23, 2018 (2018_722630_0019) with a compliance due date of January 31, 2019;
- 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 : May 07, 2019

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / No d'ordre: 008

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 89. (1) As part of the organized program of laundry services under clause 15 (1) (b) of the Act, every licensee of a long-term care home shall ensure that,

(a) procedures are developed and implemented to ensure that,

(i) residents' linens are changed at least once a week and more often as needed,

(ii) residents' personal items and clothing are labelled in a dignified manner within 48 hours of admission and of acquiring, in the case of new clothing,

(iii) residents' soiled clothes are collected, sorted, cleaned and delivered to the resident, and

(iv) there is a process to report and locate residents' lost clothing and personal items;

(b) a sufficient supply of clean linen, face cloths and bath towels are always available in the home for use by residents;

(c) linen, face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours; and

(d) industrial washers and dryers are used for the washing and drying of all laundry. O. Reg. 79/10, s. 89 (1).

Order / Ordre :

The licensee must be compliant with O.Reg. 79/10, s. 89 (1).

Specifically the licensee must:

a) Ensure that as part of the organized program of laundry services there is a sufficient supply of clean linen, face cloths and bath towels always available in the home for use by residents.

b) Ensure that face cloths and bath towels are kept clean and sanitary and are maintained in a good state of repair, free from stains and odours.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee failed to ensure that as part of the organized program of laundry services under clause 15 (1) (b) of the Act, there was a sufficient supply of clean linen, face cloths and bath towels always available in the home for use by residents and that the linen, face cloths and bath towels were kept clean and sanitary and were maintained in a good state of repair, free from stains and odours.

An anonymous complaint was reported to the Ministry of Health and Long-Term Care (MOHLTC) and documented concerns over the home's shortage of linen and towels and this had been an ongoing issue for the past few months. The caller stated during the evening shifts the staff had no towels or washcloths for bathing and washing residents. The complainant also stated that beds were not being made properly due to lack of proper bed covers. There had also been cases where residents have been sleeping on partially uncover mattresses.

The Personal Support Worker (PSW) was observed organizing towels for personal resident use and the PSW stated each resident required one half towel, one blue peri towel and one face cloth each shift. The PSW stated that typically PSWs were always short towels and it had been worse the last month or so. The PSW shared that they did not have enough half towels for resident care “today”. The PSW also stated that they would go to the tub room or search for unused towels from residents who were scheduled for a full bath. A second PSW walked by and stated that there was often not enough clean towels for evenings and sometimes there was just not enough for any shift. The PSW also stated that they would look to see if there were any leftovers from other residents; particularly those who received a full bath that day and would still have their personal care towels available. The PSW was asked if there was ever a shortage of bed linens and the PSW replied they were short fitted sheets and mostly on days. The second PWS stated two flat sheets were used when there was not enough fitted sheets. Inspector #563 and the PSWs made observations of several towels and peri cloths that were rough with frayed edges and both PSWs said that the towels were old and in disrepair.

Two PSWs were observed folding and sorting towels for personal resident use at the nursing station on Level Two A Side. One PSW stated they work evenings and the PSWs were always short towels. The PSW stated most towels were discoloured and frayed because they are washed up to six times a day and come back faded and rough. The second PSW added that two days ago the evening shift did not have one

towel to provide care. Inspector #563 asked if residents received the personal care they needed when there were not enough towels and the PSWs stated they were given "baby wipes". One PSW took the Inspector to A247 Tub Room and stated there was only enough towels for the nine baths scheduled, but at times PSWs take the bath towels, wet half of it to clean the residents and use the other half to dry them. Both PSWs shared they have reported the issue to management, but have been accused of hiding them.

Inspector #563 observed specific residents' bedding which were in a state of disrepair.

The "Laundry Room" on the Retirement Home (RH) side was observed by Inspector #563. One Guest Attendant (GA) explained that a guest attendant did the laundry for both the retirement and the Long Term Care (LTC) sections of the home. The GA explained that the linen was brought over in bags from the LTC home, it was then sorted and the towels, sheets, aprons and bed spreads on days were washed first which left the personal resident clothing as the last priority. The GAs said that if the LTC linen did not get taken over to the Laundry Room then it did not get washed. The GAs said that the LTC home did not have enough supplies for all five wings. The GAs said that if the laundry did not arrive by noon then the laundry supply for evenings would be short because each cycle took an hour to wash and another hour for drying and folding. The GA stated they washed maybe a 100 face cloths on a good day and usually only about 80. The other GA stated there was not enough linen for one shift, let alone two shifts, never mind two days. The GA also shared that they tried to divide the clean laundry between the five LTC wings so they had what they need, but they knew it was not enough. The GA said even if they washed all the linens from days for evenings on time, there was not enough supply for all the residents in the LTC home. The GA stated that they needed 300 towels and 300 face cloths to cover both shifts and the current supply was less than 100 total for the entire home. Guest Attendants (GAs) stated they also had concerns related to the condition of the linens and towels. The towels were frayed and discoloured pink, stained and the edges were torn. The GA stated they could not afford to pull the towels from circulation because the PSWs could not afford to go without them. The GAs both stated that the bed spreads were for the LTC Level One B Side and were at least 25 years old. Inspector #563 and the GAs observed bed spread together and they had frayed edges and there were multiple holes in multiple bed spreads. The white cotton bed spreads were also observed for Level One and Level 2 A Side

and they too were observed pulled and frayed. The GA stated again that if they were to take them out of circulation then the residents would not have any.

Inspector #563 then observed the laundry supply and soiled linen carts on all five LTC home areas. The linen supply carts had linens and towels available but the supply did not appear to be enough for all residents in each area.

Inspector #563 observed that a resident's fitted sheet had many holes and pink bed spread had frayed edges all the way around. Another resident's pink bed spread was observed to have had frayed edges all the way around. The Level One B Side East wing clean linen cart was contained three fitted sheets and all of them either holes, runs, rips, or stains.

A PSW stated they would discard the linen in disrepair by throwing it in the garbage and would tell the nurse. A second PSW also stated they would throw out any linens or towels in disrepair and notify the Director of Care. Neither PSW knew how the home tracked this process. The first PSW stated the home did not have enough face cloths or towels to discard any even if they were in disrepair and stated they would be happy to have towel and sheets with holes because at least that would mean they had some and shared the home was short fitted sheets "today".

The Environmental Service Supervisor (ESS) stated they were the designated lead for the laundry service program in the home. The ESS stated the home does a total linen count annually and it was done in March 2018. The ESS stated that the "Discarded Linen Inventory" was completed monthly by the Guest Attendants who were to remove the discarded laundry items from circulation and document on the number discarded as part of the inventory form. Inspector #563 showed the ESS photographs of towels, linens and bedspreads with tears, holes, discolouration and stains. The ESS stated that there were towels and linens in use presently that were in a state of disrepair.

The ESS and the Caressant Care Corporate Environmental Services Consultant (CESC) reviewed the "Linen Count March 2018" form and explained that it was an annual audit of the linen supply in the home at the time of the audit. The CESC stated it represented each of the five home areas as well as the number of linens counted that were located in the actual laundry room on the Retirement Home side. The ESS stated the "Total" column was the total linen count in the home, the

"Required" column was the supply required to provide resident care and the "Order" column was what the home needed to purchase. The ESS also clarified that the "Declared Linen Inventory" was completed monthly by the Guest Attendants who worked in the laundry room and represented the number of linens declared in disrepair and removed from circulation.

The home's "Linen Inventory" policy last reviewed April 2018 stated the “Nursing Home staff and Retirement Home staff will conduct an annual count of all linens in circulation and in storage”. “The quantities and types of linens discarded will be communicated to the Executive Director or delegate, who places a monthly linen order to ensure replacement of discarded items.” “At all times there will be a supply of clean linen (including sheets, pillow cases, blankets, towels, face cloths, bibs, and continence care supplies) sufficient to meet resident needs, readily available for use.”

The Caressant Care Nursing & Retirement Homes Ltd. "Repair and Disposal of Linens" policy last reviewed April 2018 stated, "Linens shall be maintained in a good state of repair and free of stains". "Linen shall be inspected for quality at the time of laundering" and "if an item to be used by the nursing staff is identified as being in a poor state of repair, having stains, etc., it will be brought to the attention of the Charge Nurse. The Charge Nurse will then communicate this to the Director of Care." "The frequency of such incidences will be monitored by the Director of Care. If they become excessive, the Director of Care will discuss with the Executive Director who in turn will communicate with the Retirement Home Manager (if applicable)."

The Caressant Care Nursing & Retirement Homes Ltd. "Pandemic Planning" policy effective March 2011 stated as part of the home’s preparedness that the facilities have an emergency stock pile of linens and a four to five day supply was recommended.

The ESS provided documentation related to the laundry supplies in the home which included the following:

The Woodstock Nursing Home "Linen Count March 2018" which stated “Product requirements are based on 4 days supply as per Pandemic policy.” This form documented the following:
- White Facecloth “based on 3 per/day”: there was a total of 250 counted in the

home, but 1968 were documented as required with 1718 that needed to be ordered.
- Hand Towel "based on 2 per/day": there was a total of 705 counted in the home and 1312 were documented as required with 607 that needed to be ordered.
- Blue Wash Cloth "based on 2 per/day": there was a total of 444 counted in the home and 1312 documented as required with 868 that needed to be ordered.
- Bath "based on 1 per/day": there was a total of 214 counted in the home and 656 were documented as required with 442 that needed to be ordered.
- Fitted Bottom Sheet "based on 1 per/day": there was a total of 260 counted in the home and 656 were documented as required with 396 that needed to be ordered.
- Plain Top Sheet "based on 1 per/day": there was a total of 63 counted in the home and 656 were documented as required with 593 that needed to be ordered.
- Bed Spread "based on 1 per/day": there was a total of 142 counted in the home and 164 were documented as required with 22 that needed to be ordered.
- Bibs "based on 3 per/day": there was a total of 263 counted in the home and 1968 were documented as required with 1705 that needed to be ordered

Based on a review of the documentation of the linen orders and the annual count of all linens that occurred in March 2018 did not match what was ordered on March 21, 2018 and again on April 30, 2018.

Based on these observations, interviews and record reviews, the licensee has failed to ensure there was a sufficient supply of clean linen, face cloths and bath towels always available in the home for use by residents in all five home care areas. Linen, face cloths and bath towels were not kept clean and sanitary and were not maintained in a good state of repair, and free from stains. (563) [s. 89. (1)]

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 related to a pattern. The home had a level 2 history as they had no history of non-compliance with this section of the legislation. (563)

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

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of 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.

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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 des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Order(s) of the Inspector

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

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

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

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

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

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

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d’appels
Direction de l’inspection des foyers de soins de longue durée
Ministère 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 December, 2019 (A3)

Signature of Inspector /
Signature de l’inspecteur :

Name of Inspector /
Nom de l’inspecteur :

Amended by MELANIE NORTHEY (563) - (A3)

Ontario

Ministry of Long-Term Care

Ministère des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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