Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Mar 26, 2019	2018_756583_0014 (A4)	007771-18, 007772-18, 022899-18	Resident Quality Inspection

Licensee/Titulaire de permis

Maplewood Nursing Home Limited
73 Bidwell Street TILLSONBURG ON N4G 3T8

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

Cedarwood Village
500 Queensway West SIMCOE ON N3Y 4R4

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

Amended by KELLY HAYES (583) - (A4)

Amended Inspection Summary/Résumé de l'inspection modifié

Please see change made to order #005.

3. Develop and implement a policy related to the management and use of portable or fixed supplemental ventilation units (table top, stand up fans, ceiling mounted fans or fans attached to walls) during suspected or confirmed respiratory outbreaks. The policy shall include at a minimum the necessity of using supplemental ventilation units during outbreaks, what areas they will be used in, how they will be placed to direct air flow, for how long, how they will be monitored and managed to ensure that the transmission or spread of airborne or droplet infectious pathogens are minimized and/or mitigated during their use.

Issued on this 26th day of March, 2019 (A4)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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Amended by KELLY HAYES (583) - (A4)

Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): September 12, 13, 14, 17, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, October 1, 2, 3, 4, 5, 9, 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 25, 29, 30, 31, November 1, 7, 8, 9, 13, 14 and 15, 2018.

The following intakes were completed concurrently with the Resident Quality Inspection:

Critical Incident System (CIS) Inspections

Log #005024-17, #012032-17, #023767-17, #027695-17, #002956-18, #009922-18, 028474-18, 022391-18 and #021455-18, related to an injury from a fall that resulted in a significant change in the resident's health condition.

Log #020564-17, #027073-17, #004451-18, #025138-18 #008704-18 and #026190-18, related to resident to resident altercations and repsponsive behaviours.

Log #021199-17 and 009092-18, related to outbreak of a reportable disease or communicable disease.

Log #011239-18, related to elopement.

Log #009926-18, related to skin and wound management.

Log #025848-17, #002043-18 and #028474-18, related to staff to resident neglect.

Log #004588-18 related to missing medications

Compliant Inspections

Log #001332-18, 002861-18, 016040-18, 003218-18 and 002295-18, related no 24 hour RN in the building, missing items, outbreaks, temperatures and short staffing that was affecting resident care.

Log #017618-17 and #014314-18, related to residents not receiving baths, food intake records and short staffing that was affecting resident care.

Log #024819-17, 022458-18, 015518-17, 003478-18, 023047-18 and 023245-18, related to infection prevention control, management of responsive behaviours, falls prevention management and short staffing that was affecting resident care.

Log #003055-18, #002300-18, 017784-18, 025485-18 and #024611-18, related to residents not receiving baths, and short staffing.

Log #003739-18, #004149-18 and #004854-18, related to no 24 hour RN in the building, short staffing that was affecting resident care.

Log #016668-18 related to continence care, restraining residents and short staffing.

Log #021058-18 and 023713-18 related to nutrition and hydration, access to call bells, family council and short staffing.

Log #021067-18 and 024234-18, related to short staffing that was affecting resident care and laundry service.

Log #021078-17 related to the nourishment service not being provided to residents.

Log #024655-18 related to nutrition hydration and short staffing.

Log #023309-18 and #026275-18 related to management of responsive behaviours and short staffing.

Log #000889-18 related to outbreaks and infection prevention and control.

Log #016517-17 related to restraints.

Follow Up Inspections

Log #007771-18, related to resident not being bathed a minimum of two times

per week by a method of their choice.

Log #007772-18, related to the homes procedures not being complied with in regards to the breakfast meal time.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Licensee, Attending Physician, Resident Assessment Instrument (RAI) Coordinators, Registered Dietitian (RD), Nutrition Manager (also designated lead for housekeeping and laundry services), food service workers, activity staff, housekeeping staff, laundry staff, maintenance staff, Controller, Program Manager, Administrative Assistant, Payroll, Physiotherapist (PT), Occupational Therapist (OT), Registered Nurses (RN), Registered Practical Nurses (RPN), Personal Support Workers (PSW), residents and families.

During the course of the inspection, the Inspector(s) toured the home, completed observations of the provision of care, medication administration, dining and snack services, resident programs and the homes environment. Inspector(s) reviewed resident clinical records including resident plans of care, the homes policies and procedures, the homes investigation notes, quality and improvement systems, staff training records and the homes staffing mix and payroll records. Residents' and Family Council documentation was reviewed and interviews were completed with members of the Councils.

The following Inspection Protocols were used during this inspection:

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

During the course of the original inspection, Non-Compliances were issued.
- **46 WN(s)**
- **21 VPC(s)**
- **15 CO(s)**
- **2 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. 8. (1)	CO #002	2017_695156_0008	586

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES

Legend	Légende
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	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. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A complaint was received by the MOHLTC that tub rooms were often left unlocked by employees, allowing residents to have access to disinfection products within the tub room.

During the inspection on two occasions, a tub room in the home was observed to be wide open with no staff present or in sight. Within the tub room was a towel warmer set to 65 degrees Celsius. When the surface was touched, it was very hot and the inspector could not keep their hand on the surface for more than a second without fear of receiving a burn. According to the manufacturer of the towel warmer, if set to over 43 degrees Celsius, there was a risk of burning.

In the tub room, the inspector also observed accessible concentrated tub disinfectant hooked up to the tub. The tub disinfectant was labelled as corrosive, had a high health risk and had the ability to cause digestive tract and skin burns.

The DOC, when questioned about staff leaving the tub room doors open, stated that they were aware of the issue, had addressed their concerns with staff and had been monitoring their compliance to keep the door closed and locked when not occupied by staff.

The licensee failed to ensure that the home was a safe and secure environment for its residents.

Please note that this area of non-compliance was identified during Compliant Inspection log #016668-18. [s. 5.]

Additional Required Actions:

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

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

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

s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

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

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 229 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the infection prevention and control program.

The licensee's "Infection Control Protocols: Nursing Department; Standard (Universal) Precautions; ICM-VII-040", effective March 2009, indicated that hands must be cleaned before handling and serving food and before feeding a resident.

During a meal service observation on an identified date during the inspection, PSW #100 was observed clearing plates from residents who were finished eating their meals, then serving residents dessert. The staff member was then observed

touching resident #001's bread with their bare hands while making a sandwich for them. The staff member then continued to assist other residents with eating. The staff member did not clean their hands throughout the meal service.

In an interview with PSW #119 in the dining room, they indicated that it was the expectation of the home that staff sanitize their hands between clearing and serving plates and prior to touching a resident's food. The licensee's infection control program was not implemented. [s. 229. (4)] (586)

2. The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

i) According to evidence based practices entitled "Testing, Surveillance and Management of Clostridium difficile in all Health Care Settings, January 2013" a Clostridium difficile-Associated Disease (CDI) acquired within a facility is one that includes three or more loose stools within a 24 hour period, beginning at least 72 hours post admission. The incubation period [when signs and symptoms first appear] for CDI is between five and 10 days and is transmitted from the rectum to surfaces by contaminated hands. The organism can survive on surfaces for up to five months. Further, managing cases of CDI includes establishing a mechanism for counting and keeping track of the number of confirmed cases of CDI acquired within the facility according to a standardized case definition (provided for in the document) and maintaining a summary record. The infection prevention and control designate is required to review and analyze the data on an ongoing basis, to identify any clusters and the records should be submitted as a report to the Infection Prevention and Control Committee.

A review of the meeting minutes for the Infection Prevention and Control Committee for 2018, did not include a review of any CDI statistics.

During the inspection, the DOC and Administrator were requested to provide the number of confirmed cases between 2017 and October 2018, and subsequently no records and data were provided, no summary records that could be reviewed to determine if an outbreak of CDI cases had occurred and how they were managed within the home during 2017 and 2018.

ii) The licensee submitted six Critical Incident System (CIS) reports with the

Ministry of Health and Long-Term Care (MOHLTC) identifying that their facility was experiencing either an enteric or respiratory outbreak between August 2017 and October 2018. The reports included basic facts such as number of residents and staff affected, the duration of the outbreak, whether cultures were taken and the results and whether any deaths occurred and any hospitalizations.

When records for five out of the six outbreaks were requested, only some of the information was available. A detailed summary report or record for each outbreak completed by the infection control designate in the home was not available. A review of the meeting minutes for the Infection Prevention and Control Committee for 2018, did not include a review of the outbreak or any associated statistics.

Information regarding the outbreaks in 2018, was acquired from the local public health unit and reviewed. According to public health outbreak summary reports for outbreaks in December 2017, January and February 2018, which were sent to the licensee after each outbreak, failures were identified related to timely reporting, familiarity with the outbreak process (using appropriate line listing, faxing the data on a daily basis, one designated person as point of contact with the health unit), current staff immunization records, tracking the population at risk within the home and enhanced cleaning requirements.

According to the licensee's "Infection Control Surveillance- ICM-VII-010" and "Respiratory Outbreak Protocol-ICM-VIII-020" polices, effective March 2009, the DOC or designate was required to provide the health unit with an updated line listing on a daily basis, that the RNs would initiate a surveillance form, document in progress notes on every shift the presence or absence of symptoms and that the DOC or designate would gather further data for infection tracking and reporting. The policies were reflective of public health requirements for reporting, surveillance, data collection, the implementation of general infection control measures (staff cohorting, cleaning frequencies, personal protective equipment and signage, visitor precautions), communication and overall post outbreak assessment.

During the inspection, a respiratory outbreak was in effect and the DOC reported the outbreak to public health. Surveillance forms were gathered from the registered staff for review. The names of an identified number of residents with different symptoms were listed. According to public health requirements, any two residents with the same two or more symptoms should have been reported to their local public health unit to alert them of a suspect outbreak. The licensee did

not initiate a report with public health until six days later, at which time they had additional residents with similar symptoms in the home.

The DOC was not aware that an identified number of residents presented with identified symptoms and had not reviewed or collected the surveillance sheets from the two separate nurse's stations for review. When requested to provide their monthly statistics for the last 12 months, identifying which infections were prevalent, the duration of the infections and any other trends, none could be provided as they were not collected.

The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Please note that this area of non-compliance was identified during CIS Inspection log #021199-17 and #0090992-18. [s. 229. (6)] (120)

3. The licensee failed to ensure that the following immunization and screening measures were in place:
Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Prevailing practices related to resident screening for tuberculosis can be found in a document entitled "Canadian Tuberculosis Standards, 7th edition, 2014". For residents over 65 years of age, it includes a recommendation that residents undergo a history and physical examination by a physician/nurse practitioner, which would include a symptom review for active pulmonary TB disease and a chest x-ray (posterior-anterior and lateral). The document further identified that the tuberculin skin test (TST) was not reliable and difficult to interpret in older people. A baseline 2-step TST for those 65 years old and under who also belong to an identified at-risk group was recommended. Verification was made with the Haldimand-Norfolk Health Unit in October 2018, that they have adopted the standards and expect long term care homes in their region to follow the standard.

A record listing the TB status of all residents in the home at the time of inspection was requested. An identified number of residents listed on the licensee's

"Immunization Tracker" for 2018 did not include information, as to a date of screening and the results. The remaining residents were screened using a TST with negative results.

The licensee's "TB screening for residents - ICM-V-021" policy, dated March 2009, did not include the most current best practices related to screening residents over 65 years of age. The policy referred to a 'two- step Mantoux (skin test)' on each resident. The policy further required that accurate documentation appear on the resident's electronic documentation under immunizations and in the interdisciplinary notes with regard to date, injection site and results of the test. In addition, the policy direction did not include the requirement that the resident, if screened within 90 days of admission, did not need to be screened again after admission if the results were available to the licensee.

The licensee failed to ensure that each resident admitted to the home was screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening were available to the licensee. [s. 229. (10) 1.] (120)

4. The licensee failed to ensure that the following immunization and screening measures were in place: (4) Staff is screened for tuberculosis and other infectious diseases in accordance with prevailing practices.

Prevailing practices related to staff screening for tuberculosis can be found in a document entitled "Canadian Tuberculosis Standards, 7th edition, 2014". It includes baseline screening upon hire or placement using a two-step tuberculin skin test (TST) and recommendation for an annual TST unless the conversion rate is shown to be less than 0.5%.

A record listing the TB status of all staff in the home was requested from the DOC. No record could be produced. Identified staff members stated that they were not screened for TB before they were employed by the licensee over several years prior.

The license's "TB Screening for Staff" (ICM-IV-060) policy, dated March 2009, did not include information with the exception that a two-step skin test was to be conducted before the first day of work. No guidance was provided as to who would administer the skin test and where, follow up action for individuals who

tested positive, what records were required to be produced if the staff member received TST testing elsewhere or any references to current resources and best practices.

The licensee failed to ensure that staff were screened for tuberculosis and other infectious diseases in accordance with evidence based practices. [s. 229. (10) 4.]

Additional Required Actions:

CO # - 002, 003, 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A4)
The following order(s) have been amended: CO# 002,003

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 86. Infection prevention and control program

Specifically failed to comply with the following:

s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and 2007, c. 8, s. 86. (2).
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Findings/Faits saillants :

(A3)
1. The licensee failed to ensure that the infection prevention and control program included measures to prevent the transmission of infections.

Several Complaints and Critical Incidents System (CIS) reports were reviewed during this inspection related to the infection prevention and control program.

According to Public Health Ontario and prevailing practices associated with outbreaks and measures to prevent the transmission of infections, the following practices have been identified ton reduce the number of infections, decrease the duration of outbreaks and/or mitigate negative outcomes associated with outbreaks and infections. These include but are not limited to increased cleaning and disinfection frequencies, appropriate and available personal protective equipment for staff and visitors, staff cohorting [limiting staff travel between home areas], appropriate and timely isolation procedures, hand hygiene, staff and resident immunizations, surveillance, timely reporting of potential cases and communication.

A) Complaints received included concerns regarding the lack of appropriate measures to prevent the transmission of infections.

During the inspection on three identified dates, no precautionary signage was posted upon entry to an identified number of residents' rooms regarding the type of precaution that was required. The signage would identify whether the visitor was required to wear protective gear and the type of precaution that was in place, whether contact, airborne or droplet.

According to the licensee's “Isolation Policy-ICM-IX-010" policy, transmission based precautions will be employed for all known or suspected infections for which the route is known, whether droplet, airborne or contact and staff were to obtain appropriate signage and post outside the door frame. No disinfectant supplies capable of killing the organism [product must state it can kill spores] were available in the washroom or in the room for personal support workers (PSW) to use to disinfect surfaces after they completed resident care. Registered Nurse (RN) #136 was concerned about resident safety risks associated with a disinfectant disposable wipe that was available in the home during inspection that was confirmed to be a sporicide. However, the product was not identified to be hazardous and was labeled as an irritant. If kept out of immediate reach of confused residents [i.e. stored in bathroom cabinet or on top of high wardrobe], the product was considered to be a low safety risk and the benefits of using it multiple times per day far outweighed the risks.

Concerns were identified related to nail care equipment not being disinfected adequately after use. During the inspection, both tub rooms included a storage organizer for resident supplies such as nail clippers and nail files. Each drawer

was labeled with resident names; however, an identified number of residents did not have a nail clippers in the first floor tub room. One larger nail clipper was observed sitting on a surface in both tub rooms. On a subsequent date, Inspector #586 was informed by PSW #157 that one nail clipper that was larger was used on the same residents but disinfected after use. However, the PSW did not allow the disinfectant to have adequate contact time with the clipper before rinsing it. Neither the Director of Care (DOC) or the Administrator were able to find any instructions or policies related to how all staff were to clean and disinfect commonly used nail care equipment.

Other poor infection control practices were observed during the inspection which included:
i) Improperly stored urine measure hats on grab bars, toilet tank lids, the floor or on top of cabinets in resident rooms. Some were noted to be dusty or stained.

ii) Unlabelled deodorant products, hairbrushes and toothbrushes in communal storage cabinets in resident rooms and tub room on 1st floor. The licensee's policy named 'Standard Precautions (CMVII- 040)' required that all items stored in resident rooms be labeled to identify the resident. No details were provided regarding storage of resident supplies outside of their rooms.

iii) Staff carrying exposed dirty briefs down the corridors from resident rooms to inadequately sealed garbage receptacles.

iv) The use of portable fans in corridors and resident rooms during respiratory outbreaks. Fans were also noted to be heavily coated in dust.

B) According to outbreak incident reports filed with the Ministry of Health and Long-Term Care (MOHLTC), the licensee submitted six CIS reports identifying that their facility was experiencing either an enteric or respiratory outbreak over a six-week period. The reports included basic facts such as number of residents and staff affected, the duration of the outbreak, whether cultures were taken and the results and whether any deaths or hospitalizations occurred. During the inspection, records for five out of the six outbreaks were requested, as the sixth outbreak was ongoing. A detailed summary report or record for each outbreak completed by the infection control designate was not available. A review of the meeting minutes for the Infection Prevention and Control Committee for 2018, did not include a review of the outcome of any outbreak or the statistics that were acquired to determine what future actions needed to be implemented to reduce

the duration of outbreaks or minimize the number of residents or staff affected.

Records regarding the above noted outbreaks were acquired from the local public health unit and reviewed. According to public health outbreak summary reports for outbreaks in August 2017, December 2017, January 2018 and February 2018, which were sent to the licensee after each outbreak, failures were identified related to timely reporting, familiarity with the outbreak process (using appropriate line listing, faxing the data on a daily basis, one designated person as point of contact with the health unit), current staff immunization records, surveillance and tracking the population at risk within the home and enhanced disinfection requirements.

According to the licensee's 'Infection Control Surveillance-ICM-VII-010' and 'Respiratory Outbreak Protocol-ICM-VIII-020' polices, the DOC or designate was required to provide the health unit with an updated line listing on a daily basis, that the RNs would initiate a surveillance form, document in progress notes on every shift the presence or absence of symptoms and that the DOC or designate would gather further data for infection tracking and reporting. The policies were reflective of public health requirements for reporting, surveillance, data collection, the implementation of general infection control measures (staff cohorting, cleaning frequencies, personal protective equipment and signage, visitor precautions), communication and overall post outbreak assessment.

During the inspection, a respiratory outbreak was in effect and the DOC reported the outbreak to public health on an identified date. Surveillance forms were gathered from the registered staff. The names of and identified number of residents with different symptoms were listed. According to public health requirements, any two residents with the same two or more symptoms should have been reported to their local public health unit to alert them of a possible outbreak. The licensee did not initiate a report with public health until two days later after symptoms were present, at which time they had more residents with similar symptoms on both floors of the home. As of an identified date during the inspection, residents who were identified to be in isolation for their symptoms did not have any precautionary signage posted on the door or wall upon entry to the rooms or inside the rooms.

The DOC, when interviewed and was not aware that residents presented with different symptoms and had not collected the surveillance sheets from the two separate nurse's stations for review. When requested to provide their monthly

statistics for the last 12 months, identifying which infections were prevalent, the duration of the infections and any other trends, none could be provided as they were not collected.

Interviews with housekeepers #167 and #168 and the housekeeping manager during the inspection revealed that additional hours were not always allocated during outbreaks to clean touch point surfaces in shared resident rooms and common areas. Challenges included finding staff to come into the home and financial resources. Housekeeper #167 reported that even on a day to day basis, the hours allocated to housekeepers was inadequate to provide proper and thorough cleaning. No housekeepers were present in the home beyond 1500 hours during the inspection while a respiratory outbreak was in effect. The frequency with which certain resident rooms and common areas such as dining rooms, lounges and corridors was not in accordance with outbreak control guidelines. The licensee's housekeeping policies and procedures, when reviewed, did not include current procedures and frequencies on cleaning and disinfecting the home in accordance with prevailing practices such as 'Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, April 2018'. The licensee's "Respiratory Outbreak Control Measures-ICM-VIII-021" policy, included enhanced cleaning practices in high traffic areas and the need to review cleaning protocols with the housekeeping staff through staff meetings.

The licensee therefore failed to ensure that the infection prevention and control program included measures to prevent the transmission of infections.

Please note this none compliance was identified during Compliant Inspection log #00889-18 and #016668-18 as well as during CIS Inspection log #021199-17, #029465-17, #009092-18, #03222-18 and #06346-18. [s. 86. (2) (b)] (120).

Additional Required Actions:

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

(A3)
The following order(s) have been amended: CO# 005

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

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

A) The homes investigation package and the resident's plan of care was reviewed and interviews were completed with staff. On an identified date, resident #009 was found by personal support worker (PSW) #126 in a compromised situation. PSW #126 reported it to PSW #124, who was the primary care provider for resident #009. PSW #126 then went to their assignment and did not follow up to see that resident #009 had gotten the care they required.

When the Registered Practical Nurse (RPN) went to locate the resident they found resident #009 in the same identified area still in a compromised situation.

The Directror of Care (DOC), RN #125 and RPN #118, all confirmed when interviewed that this incident met the Ministry of Health and Long Term Care (MOHLTC) legislation in regards to neglect. The home failed to ensure that resident #009 was protected from neglect. (536)

B) The homes investigation package and the resident's plan of care was reviewed and interviews were completed with staff. When PSW #106 and #157 went to resident #001's to provide care the resident was found to be in a compromised situation and had not received the care they required. The resident was upset by the incident and there were slight changes in the residents condition when they were assessed.

According to the plan of care resident #001, the resident was required to be checked at a specific interval and to be assisted by a certain number of staff.

Interviews were completed with PSW #170 and #171 who were the assigned front line staff for resident #001 during the shift. It was confirmed resident #001 was not provided the care they required using the number of staff as directed in the plan care as the staff did not work together to provided the care to the resident on this shift. It was confirmed the resident was not checked at the required intervals but it was undetermined how long the resident was in a compromised situation before the required care was provided.

In an interview with the DOC it was confirmed that resident #001 did not receive the care they required. (583)

ii) In an interview with PSW #157 who regularly provided care to resident #001 it was shared that resident #001 had other incidents where their required care was not provided as directed in their plan of care. (583)

iii) Resident #001's documented plan of care indicated that they required specified care interventions related to their condition at a certain time of day.

On an identified date during the inspection, the resident as observed to require immediate care; however PSW #106 indicated that the home was short-staffed, and due to this, there was no staff available to provided the care at the time that was directed per their plan of care. The PSW stated this happened often when short-staffed. Resident #001 was not provided care as per their plan of care. (586)

iv) A review of resident #001's plan of care showed the resident had multiple falls over an identified period related to a particular behaviour. Resident #001 was assessed to be at a risk for falls and during their last quarterly assessment and it was documented the resident had a large number of falls over the quarter. Resident #001 was assessed for a specified level of assistance for care.

In an interview with the RAI-Coordinator it was identified that often the falls incidents were related to resident #001 trying to complete a certain task related to their behaviours when left unattended. It was confirmed that an individualized plan was not developed and implemented to manage resident #001 to effectively manage their care needs.

v) Resident #001 was not administered drugs in accordance with directions for use specified by the prescriber. This was acknowledged by RPN #129.

In summary the licensee failed to provide resident #001 with the care, treatments and assistance required for their safety and wellbeing. (583)

2. The licensee failed to protect residents from abuse by anyone.

A) Documentation from resident records by registered nursing staff were reviewed that described details of a resident to resident altercation between resident #041 and resident #052 that resulted in injury to resident #052. At the time of the inspection resident #052 did not recall the incident. The licensee failed to protect resident #052 from abuse by resident #041.

B) Documentation from resident records by registered nursing staff were reviewed that described details of a resident to resident altercation between resident #038 and resident #006 that resulted in injury to resident #038 and resident #006. At the time of the inspection resident #038 recalled the incident. The licensee failed to protect the residents from abuse.

C) Documentation from resident records by registered nursing staff were reviewed that described details of a resident to resident altercation between resident #006 and resident #027 that resulted in injury to #027. The licensee failed to protect resident #027 from abuse by resident #006.

D) Documentation from resident records by registered nursing staff were reviewed that described details of a resident to resident altercation between resident #006 and resident #004 that resulted in injury to resident #004. At the time of the inspection resident #004 could not recall the incident. The licensee failed to protect resident #004 from abuse by resident #006.

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing
Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers and full body sponge baths and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

In an interview with Personal Support Worker (PSW) #107, they indicated that it was the expectation of the home that staff were to document resident bathing on paper using the 'PSW Documentation Record' as well as electronically.

A review of the bathing records (including paper records and electronic) as well as interview with the Director of Care (DOC) confirmed that not all residents were bathed at a minimum of twice a week by a method of their choice.

A) Resident #011 voiced concern to the LTCH Inspector that they had missed their scheduled bath on an identified date in 2018, as well as multiple other baths during the year. Bathing record review and interview with PSW #107 confirmed

that the resident missed their scheduled bath and did not receive this bath nor was it made up. The 'Daily 24 HR Report' also indicated that the resident's bath was missed. Review of past records also indicated that the resident missed their bath on additional dates.

B) A complaint was received from resident #010's family member that the resident was not receiving their two baths per week. Record review and interview with the DOC confirmed the resident did not receive their scheduled baths on an identified number of occasions and these baths were not made up. (506)

C) A review of the home's bathing records (including paper records and electronic) for an identified number of residents on dates over three months in 2018, where completed on selected dates where complainants identified shortages and lack of bathing. The residents reviewed missed their baths and these scheduled baths were not made up. Review of the staffing schedules confirmed that the home was short PSW staff on all of the dates identified.

D) According to the home's 'Daily 24 Hr Report' sheets, on an identified date in 2018, an identified number of residents on one of the floors did not receive their evening baths due to a staffing shortage. On another date, an identified number of residents did not receive their baths due to staffing shortage the report also indicated that the entire other floor was missed. The listed baths were not made up when the scheduled bath was missed as per bathing record documentation.

E) On two identified dates during the inspection, the home was short-staffed as confirmed by the home's management as well as staffing records. Review of the home's bathing records and interview with PSW #107 confirmed that baths were not completed for day or afternoon shifts on those dates. The residents scheduled for baths on those dates did not receive their baths, and the baths were not made up when the schedule baths were missed. [s. 33. (1)] (586)

Additional Required Actions:

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

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

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home's staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs, set out the organization and scheduling of staff shifts, promoted continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, included a back-up plan for nursing and personal care staffing that addressed 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 be evaluated and updated at least annually in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices.

From July 2017 to September 2018, the Ministry of Health and Long Term Care (MOHLTC) received 31 complaints and one Critical Incident System (CIS) report related to a staffing mix that was no consistent to meet residents' assessed care and safety needs.

Complainants shared that there were incidents where the following residents' care needs were not provided when the home was short staffed:
- Continence care
- Bathing
- Oral care
- Foot and nail care
- Dressed appropriately for time of day and in clean clothing
- Hygiene and grooming
- Preferred bedtime and rest routines
- Assistance with meals
- Snack service in the afternoon and evening
- Safe transferring and positioning techniques
- Assistance from two staff when required
- Falls prevention including monitoring of residents
- Responsive behaviours including monitoring of residents and implementing interventions

2. Cedarwood Village is a Long-Term Care Home (LTCH) with a licensed capacity of 91 beds, with 46 residents on the first floor and 45 residents on the second floor. The licensee used a "Daily Assignment Sheet" which had the following staff mix over a 24 hour (hr) period for Registered Nurses (RN), Registered Practical Nurses (RPN) and Personal Support Workers (PSW):
RN's - three staff per day, scheduled from 0600 to 1400 (hours) hrs, 1400 to 2200 hours and 2200 to 0600 hrs.

RPN's - First floor, two staff per day, scheduled from 0600 to 1400 hrs and 1400 to 2200 hrs.

- Second floor, two staff per day, scheduled from 0600 to 1800 hrs and 1800 to 0600 hrs. (except Fridays where three 8hr shifts of RPNs were scheduled)

PSW's - First and second floor each had 12 staff per day, five staff scheduled from 0600 to 1400 hrs, five staff from 1400 to 2200 hours and two staff from 2200 to 0600 hrs.

In interviews with the Administrator and Director of Care (DOC) it was confirmed that this staffing mix was used in 2018, and it was the staffing mix in place at the time of the inspection that was required to meet the residents' assessed care and safety needs.

A) The planned staffing mix for RN's in the home, for the direct care of residents, was three Registered Nurses (RN) for a total of 24 hours per day, as identified on work schedules provided by the home and confirmation by the DOC in September 2018.

During an interview with the Ward Clerk and DOC, they identified that the home did not have a sufficient number of RNs within the staffing plan to fill all shifts related to staffing events such as sick calls and vacation coverage. The DOC confirmed that the home consistently offered additional shifts to regular RNs to fill these vacant shifts; however, when the RNs employed by the home were unwilling or unable to work one or more of the required shifts, the home would fill those shifts with RPNs in combination with the DOC being on call and use an agency RN.

There were several complaints that were received by the Director in which it was identified that there were RN shortages taking place in the home. After a review of the schedules it was identified that there was no RN in the building on five shifts in July 2018, on three shifts in August 2018 and on four shifts in September 2018. In addition there were three shifts in July and one in August 2018 where an agency RN was used. The DOC confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).

Interviews were conducted with two RN's to identify if there were areas of their work routines that they were unable to complete when the homes staffing mix was not met. It was shared that staff shortages sometimes impacted resident care, specifically:
- Falls monitoring and prevention strategies aren't implemented;
- Feeding assistance;
- Weekly skin and wound assessment;

- Completion of reports and assessments when the RN has to work assisting with RPN or PSW duties during shortages; and,
- Team meetings

In an interview with the DOC it was confirmed that the home did not have any RN job routines in place to direct staff as to what care and duties they were responsible for on the various shifts.

B) The planned staffing mix for RPNs in the home for direct care of residents, was two RPNs working on each floor (totaling four) on Saturday through Thursday, and on Fridays each week, there should be three RPNs working on the second floor and two RPNs on the first floor (totaling five).

A review was conducted of the staffing levels on select dates in July and August, 2018, as many complainants identified that staff shortages often occurred in the summer months particularly over weekends. Select dates in September 2018 were also reviewed as a result of the complaints brought forward.

It was identified through staffing records that there were 19 dates between July and September 2018 where the home was short RPN shifts.

Interviews were conducted with three RPN's to identify if there were areas of their work routine that they were unable to complete when the homes staffing mix was not met. It was shared that staff shortages sometimes impacted resident care, specifically:
- Medication administration occurring late, resulting in time-sensitive medication being delayed, as well as upset residents;
- Pain assessments unable to be completed;
- Slow call bell response times, caused residents to wait extended periods of time for staff to respond;
- Reduction in time spent monitoring residents with responsive behaviours and palliative residents; and,
- Registered staff going without any breaks, even during a 12-hour shift, resulting in increased risk for error in care provided.

In an interview with the DOC it was confirmed that the home did not have any RPN job routines in place to direct staff as to what care and duties they were responsible for on the various shifts.

C) The planned staffing mix for PSW's in the home for direct care of residents, was five PSWs working on each floor of the home on day and evening shifts (totaling 10), and two PSWs working on each floor on the night shift (totaling four).

A review was conducted of the staffing levels on select dates in July and August, 2018, as many complainants identified that staff shortages often occurred in the summer months particularly over weekends. Select dates in September 2018 were also reviewed as a result of the complaints brought forward.

It was identified through staffing records that there were 25 dates between July and September 2018 where the home was short PSW shifts.

Interviews were conducted with six PSW's they confirmed PSW staff were often not able to meet all of the residents care needs as per the residents plan of care when the home had significant PSW shortages.

i) Specifically, the LTCH Inspectors received multiple complaints about the staffing levels on the Labour Day long weekend (August 31 to September 2, 2018). As indicated above, there should be ten PSWs working in the home on day and afternoon shifts. According to the Time Card Summary Report sheets for September 1, 2018, which reflected staffing punch card logs, only four PSWs worked on the day shift on September 1, 2018, to care for all 91 residents, and only five on the afternoon shift.

ii) In an interview with PSW #119 during the RQI, they indicated that call-ins were not the only reason for the staffing shortages, but also due to under-staffing prior to the shifts. A review of the daily assignment sheet for September 22, 2018, revealed that only two PSWs were scheduled to work the evening shift on the second floor, prior to the shifts and any call-ins.

iii) The home had a Professional Advisory Committee (PAC) and a meeting was held in April 2018, and the following staff were in attendance: the DOC, Physician, RD, RAI Coordinator, amongst others. The meeting minutes were reviewed. It was documented, staffing concerns limit the ability of members of the health care team to obtain information they require, related to missing documentation.

3) While inspecting the following resident care needs, actual and potential impacts to the care of residents were identified:

A) A review of the home's bathing records for three months in 2018 was completed. It revealed that certain residents missed their baths on fifteen dates in that time period and these baths were not made up. Review of the staffing schedules confirmed that the home was short PSW staff on all listed dates.

B) On an identified during the inspection in the late afternoon, seven residents were observed by the LTCH Inspector to be wearing their night time attire. An interview with PSW #134 and #135, confirmed that the above residents' plans of care did not include being placed in their night time attire prior to the dinner meal as the residents' preferences. The PSW's also confirmed that the residents were placed in their night time attire at this time because they were short PSW's to help with care later in the evening.

C) Resident #001's documented plan of care indicated that they were incontinent and required specified assistance with continence care at specified intervals.

On an identified date during the inspection, the resident as observed to require continent care; however PSW #106 indicated that the home was short-staffed, and due to this, there was no staff available to provide the specified care. Resident #001 was not provided care as per their continence plan of care.

D) On an identified date in 2017, the home was short-staffed on the day shift as confirmed by the home's investigation notes, management, as well as staffing records. A review was completed of the home's investigation notes, which stated that due to staff shortage on the identified date, a number of residents had not received the care they required and were left in a compromised situation for the oncoming shift.

During interviews with two PSWs who both worked that day, staff stated they were unable to provide the required care to all the residents because they were short staff. During interview with the DOC they confirmed that they determined that staff shortage was the reason for not completing all their assigned resident care.

E) A meal service observation was completed on an identified date during the inspection. PSW #119 was alone in the dining room with 12 residents. The PSW was observed assisting residents #003, #004 and #006 with eating. The PSW indicated that all three residents needed to be fed their meals and beverages that day. They also indicated that there were three other residents in the dining room

that required intermittent assistance. The PSW was observed going between two tables assisting residents #003, #004 and #006 as well as the other resident who required intermittent feeding assistance. Resident #002's food sat in front of them for 45 minutes and the PSW indicated that they had not had time to assist the resident yet.

Resident #003's documented plan of care indicated that they required assistance with eating. In an interview with the RD, they confirmed that resident #004 required assistance with eating. It was confirmed the resident was not provided the feeding assistance they required. It was noted the home was short eight PSWs in a 24 hr period on the identified date. (586)

F) On an identified date during the inspection, meal service was observed.

i) Review of the health records of residents #003, #004 and #005 did not include any documentation of the food or fluid intake for the meal. In an interview with PSW #107, PSW #119 and RPN #120, it was shared the expectation of the home that documentation was to be completed prior to the end of every shift; however, indicated that when the home was short-staffed, documentation would at times not get completed.

ii) PSW #119 was alone in the dining room with 13 residents. The PSW was observed assisting residents #002, #003, #004 and #005 with eating. The PSW indicated that all four residents needed to be fed their meals and beverages that day. The PSW was observed going between two tables giving each residents a few bites of their food before moving onto the next resident, in addition to clearing other residents' plates and serving them their dessert. The PSW was standing beside the residents while feeding them rather than sitting. The PSW indicated that they were aware they were not supposed to be assisting multiple residents; however, due to the lack of staffing, they were required to assist all four residents simultaneously.

Resident #003's documented plan of care indicated that they required assistance with eating. In an interview with the RD, they confirmed that resident #004 required assistance and it was confirmed the resident did not get the assistance they required with feeding. (586)

iii) A meal service was observed on an identified date during the inspection on the second floor. PSW #119 was alone in the dining room with 13 residents. The

PSW was observed assisting residents #003, #005, #002 and #004 with eating. The PSW was observed going between two tables giving each residents a few bites of their food before moving onto the next resident, in addition to clearing other residents' plates and serving the remainder of the dining room their dessert. The PSW was observed encouraging resident #003 to have some of their fluids; however, this was not done for the other residents. When all residents were finished their meals, resident #003 had one 250 ml glass of fluid and one 250ml glass of another fluid remaining that they had not consumed. Resident #004 had two 250 ml glasses remaining that they had not consumed, though the resident had attempted to drink these themselves throughout the meal without success. Resident #005 had two 250 ml glasses of fluid remaining that they had not consumed, though the resident had attempted to drink these themselves throughout the meal without success.

Resident #003's, #004's and #005's documented plan of care indicated they were at nutritional risk and that they required assistance with feeding.

PSW #119 confirmed that resident #003, #004 and #005 did not get the personal assistance and encouragement required and were not provided there required amounts of fluids. They were the only front line staff present during the meal service and shared they were short staffed. (586)

Please note that this area of non-compliance was identified during Complaint inspections.
Interview with three registered nursing staff and one PSW as well as review of the staffing schedule for the identified date, it was confirmed the home was seven PSWs short in a 24 hr period on the identified date.

G) During an observation on a specified date during the inspection, two residents were observed sitting in an identified area and no staff were present.

Resident #004 had a full container of puree snack with a spoon in it and a full beverage with a lid on it and it was observed to be on the floor in front of the resident. Resident #004 was at nutrition risk and required assistance and supervision while eating due to risk related to their medical diagnosis.

Resident #002 had a puree snack and beverage. No beverage was taken and the snack was spilled and on its side with a spoon in it. The Inspector asked if the resident could take a spoon of the snack and they were unable to feed

themselves at the time of the observation. Resident #002 was at nutrition risk and was assessed to require monitoring when eating due to risk related to their medical diagnosis. The plan of care directed staff to provide cueing and feeding assistance with eating.

It was confirmed with the Administrator, that only two out of five scheduled PSW's were working on the floor at the time of the observation. It was confirmed that resident #002 and #004 were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. (583)

Interview with RPN #118, RN #117, RPN #120 and PSW #119 as well as review of the staffing schedule for the identified date, confirmed that there were only three PSWs working on the first floor and one regular PSW and one agency PSW working on the second floor. It was noted the home was seven PSWs short in a 24 hr period on the identified date.

G) On an identified date a tour was complete of an identified floor and it was noted that a number of snacks and beverages were unfinished at resident bedsides in the home. Residents were present in some of the rooms.

An interview was completed with DA #139 it was shared the snack cart came back to the kitchen from the second floor and beverages and regular snacks were distributed but some modified texture and special snacks were returned on the cart.

In an interview with two PSWs it was shared the snacks and beverages were handed out but the staff were unable to provide feeding assistance to residents that required assistance with eating due to short staffing. It was confirmed with the Administrator that only two out of five scheduled PSW's were working on the identified floor. It was confirmed that residents on that floor who required feeding assistance were not offered assistance and therefore were not offered a beverage or snack.

4. Issues were raised by the Resident and Family Councils in regard to the staffing levels in the home.

Review of the Residents' Council meeting minutes identified the following concerns were identified to the home:

- Wait times for personal care, wait times for assessment by Registered Dietitian (RD);
- PSW staffing shortages, recommendations for programs;
- Missed baths, missing items, dietary;
- Continence care, PSW shortages, staff approach, housekeeping, lack of programs; and,
- The management of responsive behaviours, maintenance, personal care not being provided, and missing items.

The home was also aware of Family Council concerns as they received a letter, outlining their concerns in the home, mainly regarding the staffing levels and subsequent effects on resident care.

5. Inspector #586 requested to see the licensee's written staffing plan for the organized program of nursing and personal support to identify if the requirements in O. Reg. 79/10, s.31(3) were included.

A document was provided by the DOC titled, "Staffing Plan: Personal Support Workers" dated September 2018. The document indicated that it was put into place to ensure baths were being completed despite staffing shortages, and it was noted the home had a previous Compliance Order (CO) related to residents not being bathed two times per week. Except for bathing, there was no further information. It was confirmed that there was no further information detailing a staffing plan that could be located.

The Administrator and DOC confirmed that there was no staffing plan in place at the time of the inspection.
- It was unable to be confirmed if the staffing mix currently being used in the home was consistent with residents' assessed care and safety needs.
- There was no written plan that set out the organization and scheduling of staff shifts.
- There was no written plan that identified how the home promoted continuity of care or how the home minimized the number of different staff members who provided nursing and personal support services to residents. During the course of the inspection it was noted that staff would have to work on different units than they regularly worked, staff who mainly worked in other departments (food service, housekeeping) would work as a PSWs and agency staff were used due to short staffing.

Records provided by the Administrator identified agency PSW staff were used on

58 dates between July and September, 2018.
- There was no written back up plan for nursing and personal care staff to address situations when staff could not come to work.
- There was no written updates or evaluations of the staffing plan. In an interview with the Administrator in October 2018, they confirmed that the last annual evaluation of the home's staffing plan located was from 2015, and indicated that there were no other annual evaluations found since that time.

In summary, over the course of the inspection, the licensee did not meet the staffing mix set out by the home, did not meet the assessed care and safety needs of the residents and did not ensure a staffing plan was in place in the home. [s. 31. (3)] (536)

Additional Required Actions:

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

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

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 77. Food service workers, minimums

Findings/Faits saillants :

1. The licensee failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2).

The minimum number of hours per week were calculated as follows:

$M = [A \times 7 \times 0.45] + [(B \div 3) \times 0.45]$

Where,

"M" is the minimum number of hours per week for the activities outlined under subsection 77 (1) of the Regulation and the same or other activities related to meals for persons who are not residents defined under B;

"A" is the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week; and,

"B" is the total number of meals prepared in the home for the week for persons who are not residents of the home where one or both of the following two conditions are met:

(i) staff are involved in activities in addition to food preparation including but not limited to the following:
(a) distribution of meals;
(b) receiving, storing and managing of the inventory of food and food service supplies;
(c) daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service.

(ii) the menus for residents and persons who are not residents are not the same.

A review of the home's dietary job routines identified that the cook and dietary aides participated in food production, distribution of meals, inventory and cleaning for the retirement home in addition to the long-term care home. This was confirmed by cook #142 and the Nutrition Manager.

A review of food service worker regular scheduled hours through job routines and four-week schedules identified six food service staff and one cook were scheduled daily for a total of 333 hours per week. The Nutrition Manager confirmed the food service worker hours for the four week period reviewed and also identified that this was the regular scheduled hours that were in place in 2018 .

The home's minimum required hours per week, with the home above 97 per cent

capacity, was calculated as 354.9 hours.

The Administrator and Nutrition Manager acknowledged that the minimum food service worker hours were not being met by 21.9 hours per week. [s. 77.]

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that there was at least one Registered Nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Cedarwood Village is a long term care home with a licensed capacity of 91 beds. The planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was three RNs for a total of 24 hours a day, as identified on work schedules provided by the home and confirmed by the DOC in September 2018.

During an interview in September 2018, with the Ward Clerk and DOC they identified that the home did not have a sufficient number of RNs within the staffing

plan to fill all the shifts related to staffing events such as sick calls and vacation coverage. The DOC confirmed that the home consistently offered additional shifts to regular RNs to fill these vacant shifts; however, when the RNs employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with RPNs in combination with the DOC being on call and use an agency RN.

The RNs shift times over a 24 hour period were as follows:
Days 0600 to 1400 hrs
Evenings 1400 to 2200 hrs
Nights 2200 to 0600 hrs

There were several complaints that were received at the Ministry of Health in which it was identified that there were RN shortages taking place in the home. On request the home provided RN schedules over an identified period from May until October, 2018.

After a review of the schedules it was identified that there were RN shortages at the home and these dates and times were confirmed with the DOC on October 15, 2018.

- On July 20, 2018, there was no RN in the building from 0800 - 0900 hours,
- On July 21, 2018, there was no RN in the building from 1800 - 0600 hours,
- On July 23, 2018, there was no RN in the building from 1400 - 2200 hours,
- On July 24, 2018, there was no RN in the building from 1700 - 2200 hours,
- On July 25, 2018, there was no RN in the building from 1730 - 2200 hours,
- On July 25, 2018, the home used an agency RN for the night shift,
- On July 26, 2018, the home used an agency RN from 1700 - 2200 hours,
- On July 27, 2018, the home used an agency RN from 1700 - 2200 hours,
- On August 11, 2018, the home used an agency RN from 1715 - 2200 hours,
- On August 12, 2018, there was no RN in the building from 1530 - 2200 hours,
- On August 13, 2018, there was no RN in the building from 0730 - 0900 hours,
- On August 23, 2018, there was no RN in the building from 0215 - 0600 hours,
- On September 18, 2018, there was no RN in the building from 1700- 2200 hours,
- On September 19, 2018, there was no RN in the building from 1700- 2200 hours,
- On September 20, 2018, there was no RN in the building from 1700- 2200 hours,

- On September 27, 2018, there was no RN in the building from 2200- 0600 hours.

The DOC confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).
The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Please note this area of non-compliance was identified during Complaint Inspection log #004149-18, #004854-18, #004149-18 and #003007-18. [s. 8. (3)]

Additional Required Actions:

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

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were provided with food and fluids that were safe.

A) i) A lunch observation was completed in an identified dining room during the inspection. Two large containers of unlabeled bulk thickening powder were observed in the dining room. One container contained a small metal soup spoon

and the other contained a measuring spoon labelled "5cc". Inspector #583 asked spoke with the PSW staff in the dining room and it was confirmed that there were no mixing instructions or measuring spoons available in the dining room for front line staff. The mixing instructions required teaspoon (tsp) and tablespoon (tbsp) measurement tools to prepare correctly.

Two residents were observed who were assessed to be at nutrition risk that required their fluids to be thickened to a specified consistency. Staff prepared the thickened fluids for each resident in the dining room at their tableside. Both staff prepared the thickened fluids without referring to a recipe and without using measuring spoons. Both residents were observed to receive less thickening product than what was required to thicken their fluids per the mixing guide.

ii) An additional observation was completed on the same day in another dining room in the home. One large container of unlabeled bulk thickening powder was observed in the dining room. The container contained a 30 ml measuring cup. It was confirmed that there were no mixing instructions or measuring spoons available in the dining room for front line staff.

One resident was observed who was assessed at nutrition risk that required their fluids to be thickened to a specified consistency. When asked by Inspector #583 what fluid consistency the resident required they shared they didn't know and it was confirmed that staff prepared the residents thickened fluids using less thickener than required.

iii) During meal observations made on the same day containers of crushed crackers were observed to be in a bulk container. In an interview with PSW staff in the dining room they shared that they were used to thicken soup but did not have a recipe to follow. In an interview with the RD it was shared soups should be thickened using the thickener product, as the crackers do not make a smooth consistent texture. It was confirmed that there was not a process for thickening soups in the home at the time of the interview and approximately eight residents in the home required there soups to be thickened.

An interview was completed was completed with the Administrator, DOC and Food Service Manager. At the time of these observations the home was not using any pre-thickened products. It was confirmed that there were no mixing instructions or measuring spoons in any of the five dining rooms and that the front line staff did not have the information they required to prepare thickened fluids to

a safe consistency that the residents assessed to need thickened fluids required. Three residents were provided thickened fluids that were not as thick in consistency as they were assessed to require.

B) A meal observation was completed in a dining room in the home on an identified date after the above observations were made and after management in the home confirmed that front line staff did not have the information they required to prepare thickened fluids to a safe consistency.

One resident was observed who was assessed at nutrition risk that required their fluids to be thickened to a specified consistency. PSW #159 confirmed there were no mixing instructions or measuring spoons available in this dining room for staff to refer to for direction and no direction had been provided by the home. It was confirmed that staff prepared the residents thickened fluids using less thickener than required and that the fluid consistency provided to the resident was not safe.

Additional Required Actions:

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

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

Complaints were received related to resident to resident altercations involving resident #006.

On two different identified dates following a resident to resident altercation between resident #006 and resident #042, resident #042 sustained alteration in their skin integrity.

For the first incident the electronic progress notes for resident #042 were reviewed and no documentation of a skin assessment was found using the home's "Resident Wound Assessment Tool" and no further documentation was found in the progress notes showing that the area was assessed again or if it resolved.

For the second incident an alteration in resident #042's skin was documented by RPN #116 and RN #149 in the progress notes on the day following the incident.

The electronic progress notes for resident #042 were reviewed and no documentation of a skin assessment was found using the home's "Resident Wound Assessment Tool" and no further documentation was found in the progress notes showing that the area was further assessed, or if it resolved.

In an interview with the DOC, it was confirmed that an assessment was not completed by a member of the registered staff using the home's clinically appropriate instrument specially designed for skin assessments for resident #042 when they sustained an alteration in their skin integrity on two identified dates. [s. 50. (2) (b) (i)]

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

Interview with the RD, verified that residents with areas of altered skin integrity would be referred to the RD for assessment on a referral form called Registered Dietitian Referral Form.

A review of the clinical record identified that resident #044 had a new area of altered skin integrity that was identified on a specified date . There was no documentation in the clinical record of a referral to the RD. RN #136 confirmed that there was not a referral sent to the RD. [s. 50. (2) (b) (iii)]

3. The licensee failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Interview with RN #136 verified the expectation of the licensee which was that areas of altered skin integrity were to be assessed and documented weekly on the resident wound assessment form.

A) Resident #024 was identified to have an area of altered skin integrity on a specified date. A review of the clinical record did not include a reassessment of the resident's area of altered skin integrity on a weekly basis. Interview with RN #136, identified when the home changed their electronic documentation system in

April 2018, they thought the program allowed for weekly wound assessments. The RN confirmed that it was sometime in the summer that they realized that the weekly wound assessments were not being completed. At the time of this inspection the home could only produce four weekly wound assessments that were completed from April until September 2018.

B) Resident #045 was identified with two areas of altered skin integrity. A review of the clinical record for resident #045 were completed. It was identified in one month there were 21 days between completed assessments and in following month, there were 14 days between assessments. Interview with RN #136, confirmed that the weekly wound assessments were not completed.

C) Resident #044 was identified with an area of altered skin integrity. In an interview with RN #136, confirmed that there had been no further weekly wound assessments completed at the time of this inspection after the alteration in skin integrity had been initially identified. [s. 50. (2) (b) (iv)]

Additional Required Actions:

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

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were administered to residents in

accordance with the directions for use specified by the prescriber.

A) A Critical Incident System (CIS) report was submitted to the Director, regarding a missing controlled substance. Clinical record review confirmed that an identified resident had a physician's order for a medication patch and the order was to remove one patch and then apply one patch topically at an identified frequency. On an identified date, RPN #113 went to remove the patch and the patch was removed from the transparent dressing that had been applied to the resident. In an interview with the DOC it was confirmed that the resident did not receive the required dose of the medication patch as the patch was not administered to the resident in accordance with the directions for use specified by the physician. (506)

Please note this non-compliance was identified during CIS Inspection log #004588-18-18.

B) The home submitted a CIS report #2768-000022-18, related to the management of resident #001's care.

When reviewing the residents plan of care it was identified that the resident had specified continence care interventions to reduce their risk of falls. An intervention included a bowel routine ordered by the physician to manage constipation.

The clinical health records were reviewed for resident #001, #004, #054 over a 30 day period. Documentation of the resident's bowel movements and medication administration records were reviewed. The resident's eMar included a physician's orders for specified doses a stool softener and laxative to be provided at specified intervals based on the resident's bowel movements.

i) According to the resident #001 clinical health record:
They did not receive their prescribed stool softener on three required occasions.
They did not receive their prescribed laxative on two required occasions.

Resident #001 was not administered drugs in accordance with directions for use specified by the prescriber. This was acknowledged by RPN #129. (583)

Please note this non-compliance was identified during CIS Inspection log # 028474-18.

ii) According to resident #004's clinical health record:
They did not receive their prescribed stool softener on three required occasions.
They did not receive their prescribed laxative on three required occasions.

Resident #004 was not administered drugs in accordance with directions for use specified by the prescriber. This was acknowledged by staff #129. (586)

iii) According to the resident #054's clinical health record:
They did not receive their stool softener on two required occasions.
They did not receive their laxative on one required occasion.

Resident #054 was not administered drugs in accordance with directions for use specified by the prescriber. This was acknowledged by staff #129. (586) [s. 131. (2)]

Additional Required Actions:

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

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).

5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (4) Every licensee shall ensure that the persons who have received training under subsection (2) receive retraining in the areas mentioned in that subsection at times or at intervals provided for in the regulations. 2007, c. 8, s. 76. (4).

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

Findings/Faits saillants :

1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas provided for in the regulation.

A concern was voiced to Inspector #506 when they were speaking with a complainant that the home was using a Personal Support Worker (PSW) to work as a Registered Nurse (RN). A review of the schedules confirmed that the staff

member was listed on both the PSW and RN schedules. An interview with the Director of Care (DOC) confirmed that a PSW who worked at the home recently had become registered with the College of Nurses as an RN. It was noted that the staff member worked two evening shifts as the RN in charge of the building on two identified dates. An interview with the staff member, confirmed that they had not received any formal training or orientation at the home before completing their scheduled shifts as an RN in charge of the building. An interview with the DOC, confirmed they were on call when the staff member was working the above shifts and they had received some informal training prior to the shift. The DOC confirmed that the staff member should not have worked without having the required training but felt that it was better than not having an RN in the building. [s. 76. (2) 11.]

2. The licensee failed to ensure that all staff in the home received training under s. 76, subsection 2(3), the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and (2) 4, the duty under section 24 to make mandatory reports received retraining at times and intervals provided for in the regulations. In accordance with O. Reg. 79/10, s. 219. (1), the licensee was required to retrain all staff in the home annually for the purpose of 76(4) of the Act.

In October 2018, training records were received from the Director of Care (DOC). A course completion form for Abuse policy training was provided to the Inspector, and the documentation showed that 89 out of 97 (92 percent) of all staff were trained on the home's Abuse policy. It was then identified by the Inspector, that 97 was not an accurate total for all staff employed by the home in 2017. On a later date in October, 2018, additional training records were provided to the Inspector by the DOC, which stated that 93 out of 106 (87.7 percent) of all staff employed in the home in 2017, were trained on the home's Abuse policy. This was confirmed by the DOC.

However, it was identified when the Inspector asked for the actual training material, the DOC showed the Inspector that staff were actually being trained on a February 2005 abuse policy, which had been created prior to the new legislation in 2007.

During interview with staff #138 on the Inspector confirmed that a third party learning module had been started in the home in 2014. Staff #138 then confirmed that they had along with a former Administrator (who had left the home a few

years earlier), set up the training material in the third party learning module. During interview with staff #138, the Inspector was unable to verify who had actually set up the learning module in regards to the Abuse policy. The RAI Coordinator was then asked by the Inspector to view the Abuse policy training material. The RAI Coordinator confirmed that staff were being trained on a February 2005 abuse policy.

In an interview with the DOC, it was confirmed that all staff in the home did not complete annual retraining on the duty under section 24 to make mandatory reports or the home's policy to promote zero tolerance of abuse and neglect of residents and staff were not trained using home's current abuse polices.

Please note that this area of non-compliance was identified during CIS Inspection's log #002043-18 and CIS Inspection log #025848-17. [s. 76. (4)]

3. The licensee failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in 1. Abuse recognition and prevention 2. Mental Health issues, including caring for persons with dementia,3. Behaviour management at intervals provided for in the regulations and 6. Any other areas provided for in the regulations.

In accordance with O. Reg. 79/10, s. 221. (2) 1., the licensee was required to retrain all direct care staff in the home annually. In accordance with O. Reg. 79/10, s. 221. (2) 2, the licensee did not assess the individual training needs of staff members as was confirmed by the DOC during an interview.

A) The licensee failed to ensure that all staff who provided direct care to residents received training in abuse recognition and prevention.

Documents provided and confirmed by the DOC in November 2018, indicated that not all staff who provided direct care to residents in 2017, received training in the area of abuse recognition and prevention. Training records provided confirmed that of the 60 staff in the home who provided direct care to residents in 2017, 58 (97%) of those staff had not received the required training in the 2017 calendar year. (583)

B) The licensee failed to ensure that all staff who provided direct care to residents received training in metal health issues, including caring for persons

with dementia and behaviour management.

i) The DOC provided 2017 training records for three "courses" that made up the training provided to staff related to the area of mental health issues, including the care for a person with dementia. During an interview with the DOC in October 2018, they verified their hand written notes made on the document provided were accurate and confirmed that in 2017 they had 70 staff members who provided direct care to residents, as well as the accuracy of the percentages of staff who received the training.

Documents provided by the DOC indicated that:
- For the course "Working with Dementia", 6 out of 70 staff (12.9%) had not received the training.
- For the course "Calming and comforting a person living with dementia", 5 of 70 staff (7.1%) had not received the training.
- For the course "10 ways to de-escalate" 6 of 70 staff (8.6%) had not received the training.

The DOC and training records confirmed that not all staff who provided direct care to residents in 2017 received training in the area of care for a person with dementia.

ii) During an interview with the DOC in October 2018, they reviewed training records for the 2017 calendar year and verified that training in the area of behaviour management had not been provided to staff who provided direct care to residents. (129)

C) The licensee failed to ensure that all staff who provided direct care to residents received training in any other areas provided for in the regulations.

i) The licensee failed to ensure that direct care staff received annual training in the area of skin and wound management.

In accordance O. Reg. 79/10, s. 221(1) 2 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of Skin and Wound Management. Documents provided and confirmed by the DOC indicated that not all staff who provided direct care to residents in 2017, received training in the area of skin and wound management. Training records provided at the time of this inspection confirmed that of the 62 staff in the home

who provided direct care to residents in 2017, 38 (61 %) of those staff had not received the required training in the 2017 calendar year. (506)

ii) The licensee failed to ensure that all staff who provided direct care to residents received annual training in the area of falls prevention management.

In accordance O. Reg. 79/10, s. 221(1) 4 and 219 (1) the home is required to provide all staff who provide direct care to residents with annual training in the area of falls prevention and management.

Documents provided and confirmed by the DOC on October 11, 2018, indicated that not all staff who provided direct care to residents in 2017 received training in the area of falls prevention and management. Training records provided at the time of this inspection confirmed that of the 62 staff in the home who provided direct care to residents in 2017, 50 (81%) of those staff had received the required training in the 2017 calendar year. (506)

iii) The licensee failed to ensure that all staff who provided direct care to residents received annual training in the areas of skin and wound management.

In accordance O. Reg. 79/10, s. 221(1) 2 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of Skin and Wound Management. Documents provided and confirmed by the DOC indicated that not all staff who provided direct care to residents in 2017, received training in the area of skin and wound management. Training records provided at the time of this inspection confirmed that of the 62 staff in the home who provided direct care to residents in 2017, 38 (61 %) of those staff had not received the required training in the 2017 calendar year. (506)

iv) The licensee failed to ensure that staff who provided direct care to residents received annual training in the areas of continence care and bowel care.

In accordance O. Reg. 79/10, s. 221(1) 3 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of continence care and bowel management.

Documents provided and confirmed by the DOC in November 2018 indicated that not all staff who provided direct care to residents in 2017, received training in the area of continence care and bowel management. Training records provided at the

time of this inspection confirmed that of the 62 staff in the home who provided direct care to residents in 2017, 29 (47 %) of those staff had not received the required training in the 2017 calendar year. (583) [s. 76. (7)]

Additional Required Actions:

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

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas provided for in the regulation, to be implemented voluntarily.

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

Specifically failed to comply with the following:

s. 73. (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:
1. Communication of the seven-day and daily menus to residents. O. Reg. 79/10, s. 73 (1).

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:
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. O. Reg. 79/10, s. 73 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the home had a dining and snack service program that included communication of the seven-day and daily menus to residents.

In September 2018, a tour of the home was completed by the LTCH Inspector. Upon observation it was identified that the home's seven-day menus were not posted in the home, except for one dining room where a menu posted behind the servery; however, this was not in view for residents. This was confirmed by the Nutrition Manager. [s. 73. (1) 1.]

2. The licensee failed to ensure that residents were provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) During a meal service observation on an identified date during the inspection, resident #006 was observed with their entrée in front of them from for 30 minutes when they were then provided with cueing to eat. PSW #100 then cut the

resident's food, but they only ate one bite, then the PSW didn't encouraged the resident to eat again for another 20 minutes. The resident was served dessert which they ate in full. Ten minutes later, RPN #102 encouraged the resident further, and they began eating some more of their entrée but staff failed to offer resident their special nutrition intervention as directed in the plan of care.

Resident #006's was assessed to be at nutritional risk and their plan of care directed staff to provided encouragement at meals. This was confirmed in an interview with RPN #102 and it was confirmed resident #006 did not receive the encouragment and assistance they required during the meal service. (586)

B) A meal service observation was completed on an identified date during the inspection. PSW #119 was alone in the dining room with 12 residents. The PSW was observed assisting residents #003, #004 and #006 with eating. The PSW indicated that all three residents needed to be fed their meals and beverages that day. They also indicated that there were three other residents in the dining room that required intermittent assistance. The PSW was observed going between two tables assisting residents #003, #004 and #006 as well as the other resident who required intermittent feeding assistance. Resident #002's food sat in front of them for 45 minutes and the PSW indicated that they had not had time to assist the resident yet.

Resident #003's documented plan of care indicated that they required assistance with eating. In an interview with the RD, they confirmed that resident #004 required assistance with eating. It was confirmed the resident was not provided the feeding assistance they required. (586)

C) i) A meal service was observed on an identified date during the inspection. PSW #119 was alone in the dining room with 13 residents. The PSW was observed assisting residents #002, #003, #004 and #005 with eating. The PSW indicated that all four residents needed to be fed their meals and beverages that day. The PSW was observed going between two tables giving each residents a few bites of their food before moving onto the next resident, in addition to clearing other residents' plates and serving them their dessert. The PSW was standing beside the residents while feeding them rather than sitting. The PSW indicated that they were aware they were not supposed to be assisting multiple residents; however, due to the lack of staffing, they were required to assist all four residents simultaneously.

Resident #003's documented plan of care indicated that they required assistance with eating. In an interview with the RD, they confirmed that resident #004 required assistance and it was confirmed the resident did not get the assistance they required with feeding. (586)

ii) A meal service was observed on an identified date during the inspection on the second floor. PSW #119 was alone in the dining room with 13 residents. The PSW was observed assisting residents #003, #005, #002 and #004 with eating. The PSW was observed going between two tables giving each residents a few bites of their food before moving onto the next resident, in addition to clearing other residents' plates and serving the remainder of the dining room their dessert. The PSW was observed encouraging resident #003 to have some of their fluids; however, this was not done for the other residents. When all residents were finished their meals, resident #003 had one 250 ml glass of fluid and one 250ml glass of another fluid remaining that they had not consumed. Resident #004 had two 250 ml glasses remaining that they had not consumed, though the resident had attempted to drink these themselves throughout the meal without success. Resident #005 had two 250 ml glasses of fluid remaining that they had not consumed, though the resident had attempted to drink these themselves throughout the meal without success.

Resident #003's, #004's and #005's documented plan of care indicated they were at nutritional risk and that they required assistance with feeding.

PSW #119 confirmed that resident #003, #004 and #005 did not get the personal assistance and encouragement required and were not provided there required amounts of fluids. They were the only front line staff present during the meal service and shared they were short staffed. (586)

Please note that this area of non-compliance was identified during Complaint inspections.

D) During an observation on a specified date during the inspection, two residents were observed sitting in an identified area and no staff were present.

Resident #004 had a full container of puree snack with a spoon in it and a full beverage with a lid on it which was observed to be on the floor in front of the resident. Resident #004 was at nutrition risk and required assistance and supervision while eating due to risk related to their medical diagnosis.

Resident #002 had a puree snack and beverage. No beverage was taken and the snack was spilled and on its side with a spoon in it. The Inspector asked if the resident could take a spoon of the snack and they were unable to feed themselves at the time of my observation. Resident #002 was at nutrition risk and was assessed to require monitoring when eating due to risk related to their medical diagnosis. The plan of care directed staff to provide cueing and feeding assistance with eating.

It was confirmed with the Administrator, that only two out of five scheduled PSW's were working on the floor at the time of the observation. It was confirmed that resident #002 and #004 were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. (583)

Please note that this area of non-compliance was identified during Complaint inspections.

E) During an observation on an identified date and time during the inspection, a resident room was observed and two residents were observed with food at their bedside with no staff present. No food was taken.

Resident #025 had a full thickened beverage at their bed side and no snack. Resident #025 was assessed at nutrition risk. The plan of care identified the resident required feeding assistance with eating.

Resident #046 had a full beverage and pureed snack at their bedside. Resident #046 was assessed at nutrition risk. The plan of care directed staff to monitor the resident while eating due to risk related to their medical diagnosis.

In an interview with PSW #119 and #132, it was confirmed that resident #025 and #046 were not provided with the personal assistance and monitoring required to safely eat and drink as comfortably and independently as possible. During the interview it was shared the snacks and beverages were handed out at during snack service but the staff were unable to provide feeding assistance to residents that required assistance with eating due to short staffing. It was confirmed that none of the residents who required feeding assistance with their beverage or food were provided assistance on the floor. (583)

Weight reports over an identified period were evaluated for the residents noted above who were identified as not having received the assistance they required from staff for feeding. It was documented that resident #002, #003, #004, #006, #016, #046 and #063 all had ongoing monthly weight loss over an identified time period. It was noted that resident #004 loss greater than 7.5 percent of their body weight over an identified period and that resident #002 and #046 lost greater than 10 percent of their body weight in an identified period. [s. 73. (1) 9.]

3. The licensee has failed to ensure that a resident who required assistance with eating or drinking was not served a meal until someone was available to provide assistance required by the resident.

A) On an identified date during the inspection, a meal service was observed. Resident #003 was observed with their entrée in front of them at an identified time with no staff present at their table. PSW #119 confirmed that the resident's entrée had been sitting in front of them for approximately 45 minutes. Resident #003's plan of care identified they required assistance from staff with feeding.

The PSW shared they were not available to provide assistance till that time as they were short front line staff in the dining room. PSW #119 was noted to be the only staff present for the dining service.

B) During a dinner observation on an identified date during the inspection, resident #016 was observed with their entrée in front of them at the dining table with no staff present at their table. RN #117 wasn't able to assist the resident and confirmed that their entrée had been sitting in front of them for 25 minutes. Resident #016's plan of care directed staff to provide total feeding assistance.

The RN shared they were not available to provide assistance till that time as they were short front line staff in the dining room. RN #117 was noted to be the only staff present for the dining service. [s. 73. (2) (b)]

Additional Required Actions:

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

WN #14: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

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

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that there was a written plan of care for each resident that set out the planned care for the resident.

A) A review of resident #002's documented plan of care, which front line staff use to direct care, indicated that the resident required set up and cueing to brush their

own teeth. Through interview with Personal Support Worker (PSW) #146 and Registered Practical Nurse (RPN) #102 it was identified that the resident required the specialized interventions related to their mouth care. This planned care was not included in the resident's plan of care. (586)

B) An observation of resident #055, identified that the resident was using falls prevention interventions and devices. In an interview with Resident Assessment Intrument (RAI) Co-ordinator #129, it was confirmed these specific fall interventions were in place to prevent injury if the resident were to fall. A review of the care plan under the fall focus did not include the resident using these specific fall prevention strategies. In an interview with RAI co-ordinator #129 it was confirmed that these interventions were not included in the care plan and did not set out the planned care for resident #055. (506)

Please note this non-compliance was identified during CIS Inspection log #022391-18.

C) An observation of resident #046, identified that the resident was using two types of falls interventions. In an interview with RAI co-ordinator #129, it was confirmed these specific fall interventions were in place to prevent injury if the resident were to fall. A review of the care plan under the fall focus did not include the resident using these specific fall prevention strategies. In an interview with RAI co-ordinator #129, it was confirmed that these interventions were not included in the care plan and did not set out the planned care for resident #046.

The above non-compliance was identified during CIS Inspection log #021455-18. (506) [s. 6. (1) (a)]

2. The licensee failed to ensure that the plan of care set out clear directions to staff and others who provided direct care to the residents.

A) Resident #010's written plan of care was reviewed. Under the activities of daily of living focus, the plan indicated a specific bathing intervention. Interview with PSW #109, confirmed that the resident has tub baths only and could not confirm if the resident ever only had sponge baths. Interview with RPN #108, confirmed that plan did not set out clear directions to staff and others who provide direct care to the resident regarding their method of bathing.

Please note this non-compliance was identified during Complaint inspections log

#014314-18 and #017618-17.

B) Resident #009's written plan of care was reviewed. Under the activities of daily living focus, the plan indicated that the resident was to be provided a specified bathing intervention as others could not be tolerated. An interview with PSW #013, #114 and #115 confirmed, that the resident did not use the specified bathing intervention and that the plan of care did not set out clear directions to staff and others who provide direct care to the resident regarding their method of bathing.

Resident #009's written plan of care was reviewed. Under the oral/dental care focus, the plan indicated that staff were to apply upper and lower dentures daily. Interview with PSW #103 and #115 confirmed, that the resident no longer wears dentures and confirmed that the plan of care did not set out clear directions to staff and others who provide direct care to the resident regarding their oral/dental care.

[s. 6. (1) (c)]

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

A clinical record review identified the resident was assessed as being at risk for falls. A review of the care plan that was in place during this time did not include a focus, goals and interventions based on the assessed needs for resident #055 for fall prevention strategies. A care plan was created on an identified date, after the resident fell and sustained an injury. An interview with RAI Co-ordinator #129 confirmed that the resident was assessed at risk for falls and the plan of care did not include the assessed needs or preferences for resident #055 for fall prevention strategies.

Please note that this area of non-compliance was identified during CIS Inspection log #022391-18. [s. 6. (2)]

4. The licensee failed to ensure that staff and others involved in the different aspects of care of the resident collaborated with each other, in the assessment of the resident so that their assessments were integrated, consistent and complemented each other in the development and implementation of the plan of care so that the different aspects of the care were integrated, consistent and

complemented each other.

Nursing staff and staff providing service to resident #006 from the Behavioural Support Ontario (BSO) program did not collaborate in the assessment of the resident and the development of the plan of care related to the management of responsive behaviours demonstrated by resident #006.

The Director was notified by staff in the home through Critical Incident Reports (CIR) that resident #006 demonstrated responsive behaviours on identified dates.

Following a review of resident #006's paper clinical record, the Inspector noted Behavioural Support Ontario (BSO) clinical notes which directed the reader to "see recommendation list". During an interview with RN #136, they were asked to provide the recommendation list that BSO staff referred to in the clinical record. RN #136 said they did not know where a recommendation list would be or what information may be on the recommendation list. RN #136 confirmed that they do not communicate with BSO staff and they do not read notes left by BSO staff.

During an interview with the DOC, they confirmed that there is not communication with BSO staff and that the home doesn't know which residents staff from BSO are working with. RAI Co-ordinator #129 entered the DOC's office at the time of this interview and also verified that there is no communication between the home staff and BSO staff. Both the DOC and the RAI Co-ordinator indicated that they had been aware of this, saw this a problem related to the management of responsive behaviours in the home and indicated they had sent an email to the manager of BSO requesting they be made aware of the resident's being seen by BSO staff.

The DOC explained, that BSO staff and staff in the home held what was referred to as "910 meetings" and that each meeting a resident was selected for discussion at the meeting. The resident selected for discussion would usually be a resident whose responsive behaviours continued to be challenging to manage. While reviewing resident #006's clinical record there was a document that RN #136 identified as a "910 meeting". RN #136 reviewed the document and verified that no staff person from the home had attended the meeting.

During an interview with staff #161, who was both an employee of the home and familiar with BSO staff's interaction with staff in the home, it was identified that

there was not communication with the registered staff in the home and staff from BSO related to the care of residents who demonstrate responsive behaviors.

At the time of this inspection the DOC was unable to provide any evidence that recommendations for care made by BSO staff had been included in the care directions for staff who provided care to resident

The DOC, RN #136, RPN #129, staff #161 and resident #006's clinical record confirmed that the licensee failed to ensure that nursing staff and staff providing service to resident #006 from the Behavioural Support Ontario (BSO) program collaborated in the assessment of the resident and the development of the plan of care related to the management of responsive behaviours demonstrated by resident #006.

Please note this area of non-compliance was identified during CIS Inspections log #026190-18, #027073-17, #020564-17 and #025138-18. [s. 6. (4)]

5. The licensee has failed to ensure that care was provided to the resident as per the plan of care.

A) On an identified date during the inspection, at an identified time resident #041's call bell was noted to be ringing. The LTCH Inspector went down to the room and noted that the resident was left unattended in an identified area. Approximately five minutes later RAI co-ordinator #129 went and tended to the resident. A review of the resident's clinical record confirmed that the resident was not to be left unattended in this area. In an interview with RAI co-ordinator #138 it was confirmed that the resident's plan of care was not followed as the resident was not to be left unattended as the resident could be unpredictable and had been known to self transfer.

The licensee failed to ensure that the care set out in the plan of care was provided to resident #041 as specified in the plan. (506)

B) On an identified date, resident #042 returned from hospital. In a progress note by RN #136 it was documented that the physician assessed the resident and ordered a specified therapy for the resident to be completed by a member of the allied heath team for specified intervals daily. In an interview with the allied health team member and the DOC it was confirmed the referral was not sent when the physician ordered the therapy. The licensee failed to ensure that the specified

therapy was provided to resident #042 for an identified time period, as specified in their plan of care. (583)

C) Resident #002's documented plan of care included the use of a personal-assistance services device (PASD), indicating, with specified details for use and timing. The resident was observed on two identified dates, with the PASD applied when it was not directed to be used.

In an interview with PSW #146, they indicated they were unclear about the direction on the plan of care and had been applying the PASD at all times. In an interview with RAI Coordinator #129, they confirmed that the resident should only have the PASD applied at the specified times and that it was to be removed at all other times. Resident #004 was not provided the care specified in the plan of care. (586)

D) A call bell was observed ringing for an identified time period on an identified date. Inspector #583 entered resident #057's area with their permission and the resident was found in a compromised situation requiring care. They could not recall how long they were waiting for assistance.

Inspector left room and PSW #166 entered the resident room and provided assistance. When the staff exited the residents room it was confirmed that the required care and transferring assistance was provide by one staff. The resident's plan of care was reviewed and it directed two staff to provide assistance for the type of care that was provided.

In an interview with the DOC, it was confirmed the plan of care identified resident #057 required two staff for the required care, therefore care was not provided as directed in the plan of care. (583) [s. 6. (7)]

6. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs changed or care set out in the plan was no longer necessary.

On two identified dates during the inspection, resident #047 was observed without a falls intervention in place that was in their plan of care. Review of the plan of care for resident #047 identified the resident was at risk for falls and the identified interventions should be in place at all times. In an interview with the restorative

care aide, it was shared the resident did not have the intervention in place anymore. The DOC confirmed that the plan of care should have been revised when the intervention was removed and the resident's care needs changed.

Please note that this non-compliance was identified during CIS inspection log #027695-17. [s. 6. (10) (b)]

7. Resident #047's and #046's plan of care was not reviewed and revised when the care set out in the resident's plan of care had not been effective in relation to the identified falls care focus.

A) The care plan in effect for resident #047, confirmed that the resident was at risk for falls and a current goal that the resident would have no falls through the review date. Several interventions were included in the care plan.

Over an identified time period the resident had a specified number of falls that resulted in injury.

A clinical record review confirmed that the care plan had not been revised when the care set out in the plan had not been effective and the goal was not met after each fall and there were no additional care interventions implemented during the time period of these falls.

In an interview with RAI co-ordinator #138, they confirmed that the plan of care was not revised when the care in the plan was not effective in mitigating the resident's risk of falls. (506)

Please note that this area of non-compliance was identified during CIS Inspection log #027695-17.

B) The care plan in effect for resident #046, confirmed that the resident was at risk for falls and a current goal that the resident would have no falls through the review date.
Several interventions included in the care plan.

Over an identified time period the resident had a specified number of falls that resulted in injury.

A clinical record review confirmed that the care plan had not been revised when

the care set out in the plan had not been effective and the goal was not met after each fall and there were no additional care interventions implemented prior to the resident falling and sustaining an injury. In an interview with RAI co-ordinator #129 they confirmed that the plan of care was not revised when the care in the plan was not effective in mitigating the resident's risk of falls.

Please note this area of non-compliance was identified during CIS Inspection log #021455-18. [s. 6. (10) (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 there is a written plan of care for each resident that sets out, the planned care for the resident; to ensure that the care set out in the plan of care is based on the assessment, needs and preferences of the resident; to ensure that staff and others involved in the different aspects of care of the resident collaborate with each other in the assessment of the resident and in the development and implementation of the plan of care, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with O. Reg. 79/10, s. 31, the licensee was required to have an organized program of nursing and personal support services, and with s. 30 (1), to ensure that the program had relevant policies, procedures and protocols developed.

The licensee's policy, "Bed Linen Changes" (NDM-III-74, last reviewed June 2005) indicated that a complete bed linen change was to be done at least weekly, but that beds were routinely changed on the day of the resident's bath, as part of the licensee's nursing and personal support services program. Interviews with housekeeping staff #156 and #158 and PSWs #157 and #110 confirmed that bed lines were changed on each resident's bath day.

Complaints were received identifying concerns from resident's persons of importance were not being changed on a weekly basis.

A) During observations over an identified time period it was observed that an identified resident's bed sheets were not changed. This was acknowledged by PSW #110. The resident had been given two baths and the resident's bed linens were not changed on the day of the baths nor on a weekly basis, as per the licensee's policy. (586)

Please note that this area of non-compliance was identified during Complaint

Inspection, log #021067-18.

2. In accordance with O. Reg. s. 68, the licensee was required to ensure that the nutrition care program included a system to monitor and evaluate the fluid intake of residents with identified risk related to nutrition and hydration.

Specifically, staff did not comply with the licensee's policy titled, Hydration Assessment and Management, last revised July 2014. The Policy contained an "Algorithm for Assessment and Management of Hydration" and directed nursing staff to calculate the total daily fluid intake of all residents every 24 hours. When the a residents fluid intake was less than 1200 (milliliters) ml and fluid intake continued to remain low for three consecutive days a referral was to be sent to the RD.

A) Resident #063 was assessed to be at nutrition risk and it was documented in the nutrition care plan goal, to maintain/achieve adequate hydration by fluid intake greater than 75 percent of the residents specified fluid goal.
The fluid intake records were reviewed and it was documented that resident #063 consumed less than 50 percent of their fluid requirements for an identified number of days in a row.

In an interview with the RD, it was confirmed that they did not receive a referral to notify them that resident #063 had low fluid.

B) A concern was shared that resident #040 and other residents in the home may not be offered their required amounts of fluids daily. Resident #040 was assessed to be at nutrition risk and it was documented in the nutrition care plan goal, to maintain/achieve adequate hydration by fluid intake greater than 75 percent of the residents specified fluid goal.

The fluid intake records were reviewed and it was documented that resident #040 consumed less than 75 percent of their fluid goal for an identified number of days in a row.

In an interview with the RD, it was confirmed they did not receive a referral to notify them that resident #063 had low fluid intake.

It was identified referrals were sent to the RD in a paper format. The RD shared they only received "a couple" of referrals in 2018 related to residents with low fluid

intake and confirmed referrals were not always being sent when a resident had a fluid intake of less than 1200 ml for four consecutive days per the home procedure. (583)

3. In accordance with O. Reg. s. 48, the licensee was required to ensure that the continence care and bowel management program to promote continence and ensure that residents were kept clean, dry and comfortable were implemented.

Specifically, staff did not comply with the licensee's strategy for the application of continence care products used in the home.
The home's vendor instructions for the application of briefs directed the following:
- Select the right size product according to the resident's plan of care, a brief that is too large will result in leakage.
- Ensure the lining is next to the resident's skin.
- Don't use more than one product at a time, double padding creates discomfort and skin irritation.

The Policy titled Continence Care and Bowel Management Program, NDM-II-240, last revised April 2017, identified resident were to be provided with a range of continence care products that:
- Were based on their individual assessment needs
- Properly fit the resident
- Promoted resident comfort, dignity and good skin integrity

The Administrator provided a copy of direction that was provided to staff in the home on i) in December 2017, in the form of a paper memorandum. It directed staff not to wrap resident incontinence products around slings or clothing and referenced that briefs should be applied in the manner which was appropriate to provide proper continence and skin care and ii) in August 2018, in the form of an electronic message on the facility bulletin board, directed staff not to wrap incontinence products around resident slings.

In an interview with the DOC it was confirmed the licensee failed to ensure that the homes strategy for the application of continence care products used in the home was complied with as observed for identified residents on identified dates.

Please note that this area of non-compliance was identified during Complaint inspection, log #016668-18, conducted concurrently during this RQI. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's Bed Linen policy, Hydration Assessment and Management policy and the application of continence care products strategy are complied with, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the home was maintained at a minimum of 22 (C) degrees Celsius.

On an identified date in October 2018, no heat was turned on in multiple locations throughout the home, including resident rooms. The home was equipped with electric baseboard heaters as a source of primary heat and forced air heating as a secondary source. Residents complained about the cold while in the common area and while sitting in chairs in their rooms with blankets on. The outdoor temperature was between 5.8C and 8.5C. Inspector #120 noted how cool it felt in the home and visited an identified number of resident rooms, lounge and both dining rooms. None of these rooms had the room thermostats turned on. The heaters were cold to the touch and the fresh air blowing in through the ceiling vents was 11-13.8C [when measured with an infrared thermometer]. The inspector turned on all of the above noted thermostats to determine their functionality. All produced heat after several minutes. The inspector took air temperatures using a digital hygrometer in an identified resident room, lounge and large dining room. The temperatures were 21C, 20C and 21C.

The Director of Care (DOC), who was interviewed about air temperature monitoring, stated that they had just removed the temperature forms from the nurses' stations and dining rooms. When reviewed, staff were recording air temperatures up until an identified date in September 2018, to determine when to initiate heat related symptom interventions. The DOC realized that the temperatures needed to be monitored year round and replaced the logs at the time of inspection in dining rooms, lounges and at the nurses' stations for nursing staff to continue monitoring. Discussion was also held about all staff being aware of air temperatures in resident's rooms and ensuring that they set the thermostats accordingly.

The licensee failed to ensure that the home was maintained at a minimum of 22C. [s. 21.]

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 is maintained at a minimum temperature of 22 degrees Celsius, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
11. Seasonal risk relating to hot weather. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident's plan of care was based on, at a minimum, an interdisciplinary assessment of continence, including bladder and bowel elimination.

A review of resident #054's documented plan of care, which front line staff use to direct care, did not include any information on the resident's bowel continence. In an interview with RAI Coordinator #129, they confirmed this and indicated that this information should have been included in the plan of care.

Please note that this area of non-compliance was identified during Complaint Inspections, log #023309-18 and #026275-18. [s. 26. (3) 8.]

2. The licensee failed to ensure that the resident's plan of care was based on, at a minimum, an interdisciplinary assessment of seasonal risk relating to hot weather.

Several complaints (log #016040-18, #016668-18, #002295-18 and #001332-18) were received by the Ministry of Health and Long Term Care regarding concerns for residents' well-being during excessive heat episodes over the summer months of 2018. Based on the complainants, many residents appeared lethargic and unwell during the extreme heat episodes, especially resident #002. One complainant was concerned that the resident was not getting adequate hydration during extreme heat episodes.

During the inspection in October 2018, based on a review of air temperature logs and interview with numerous staff, designated lounges and dining rooms were air conditioned throughout the summer, and only certain resident rooms were equipped with air conditioning units.

Heat stress assessments and the residents' plan of care were reviewed for an identified number of residents who were confirmed not to have air conditioning units in their rooms.

Resident #002, #022 and #052 were assessed as risk for heat stress with identified risk factors. According to the resident's plan of care, there was no focus, goal or interventions for the resident's status with respect to heat stress included. Although each of their health conditions were identified in the plan of care, and interventions associated with them included, it was not clear exactly what health care staff were to do when environmental conditions, such as humidity and temperature became uncomfortable and could impact the resident's health negatively for each identified condition. Under the focus of "Nutrition", no interventions were included that related to heat risk and did not direct care staff as to when to increase monitoring of intake, how often to monitor and whether the intake would be documented.

The licensee failed to ensure that the resident's plan of care was based on, at a minimum, an interdisciplinary assessment of seasonal risk relating to hot weather. [s. 26. (3) 11.]

3. The licensee failed to ensure that the resident's plan of care was based on, at a minimum, an interdisciplinary assessment of dental and oral status, including oral hygiene.

A review of resident #016's documented plan of care, which front line staff use to direct care, did not include any information on the resident's oral care status or care requirements. In an interview with RAI Coordinator #129, they confirmed this and indicated that this information should have been included in the plan of care. [s. 26. (3) 12.]

4. The licensee failed to ensure that the resident's plan of care was based on, at a minimum, an interdisciplinary assessment of the sleep patterns and preferences.

A complainant voiced concern to Inspector #583 that the resident liked to be put into bed for rest at specified times, but was unsure if this was in the resident's documented plan of care. In an interview with resident #056, they confirmed that like to be put into bed for rest at the specified times the complainant identified. In an interview with front line staff they also confirmed this was the residents preference.

A review of resident #056's documented plan of care, which front line staff use to direct care, did not include any information on the resident's sleep patterns and preferences. In an interview with RAI Coordinator #138 they confirmed this and indicated that this information should have been included in the plan of care.

Please note that this area of non-compliance was identified during Complaint inspections, log #002300-18 and #017784-18. [s. 26. (3) 21.]

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 resident's plan of care is based on, at a minimum, an interdisciplinary assessment of continence, including bladder and bowel elimination; of seasonal risk relating to hot weather; of dental and oral status, including oral hygiene; and of the sleep patterns and preferences, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

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

Findings/Faits saillants :

1. The licensee failed to ensure that documentation was kept of the dates changes were made and implemented in relation to the skin and wound and falls prevention program evaluation.

A) A review was of the Skin and Wound program evaluation that was completed in November of 2017. The licensee identified an identified number of areas of improvement and changes that were to be implemented and no dates were identified when the changes were implemented. This was confirmed with the DOC during an interview in October 2018.

B) The DOC provided the most recent annual program evaluation for the Falls Prevention program. The documents provided, confirmed that as a result of the program evaluation the licensee identified plans in order to improve the quality of the care and services to the residents, however the dates when the action plans were implemented were not included in the documents provided. [s. 30. (1) 4.]

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

On an identified date during the inspection, meal service was observed. Review of the health records of residents #003, #004 and #005 did not include any documentation of the food or fluid intake for the meal. In an interview with PSW #107, PSW #119 and RPN #120, it was the expectation of the home that documentation was to be completed prior to the end of every shift; however, indicated that when the home was short-staffed, documentation would at times not get completed. [s. 30. (2)]

Additional Required Actions:

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

WN #19: 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,
(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable.

On an identified date during the inspection, Inspector #583 and #586 requested to observe resident #051's care. Continence care was provided by PSW staff #106 and #160 and it was confirmed that resident was in a compromised situation.

Resident #051's continence care plan directed staff to check the resident at least every two hours for incontinence. An interview was completed with four PSW's working on the unit and it was confirmed no one check the resident for approximately five and a half hours. It was confirmed that resident #051 did not receive sufficient changes to remain clean and dry. [s. 51. (2) (g)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents who required continence care products had sufficient changes to remain clean, dry and comfortable, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (1) Every licensee of a long-term care home shall ensure that the following are developed to meet the needs of residents with responsive behaviours:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other. O. Reg. 79/10, s. 53 (1).
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours. O. Reg. 79/10, s. 53 (1).
3. Resident monitoring and internal reporting protocols. O. Reg. 79/10, s. 53 (1).
4. Protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 53 (1).

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other were developed.

A) Resident #054's documented plan of care, which front line staff use to direct care, indicated that the resident exhibited a number of responsive behaviours.

In an interview with PSW #146 and #013 they identified techniques and interventions that the staff that knew the resident well, used to help manage the resident's responsive behaviours. The techniques and interventions to prevent, minimize or respond to the responsive behaviours that the staff identified were not included in the resident's documented plan of care. This was acknowledged by RAI Coordinator #129.

Please note that this area of non-compliance was identified during Complaint Inspections, log #023309-18 and #026275-18.

B) The licensee did not develop written approaches for care related to the identification of behavioural triggers to meet the needs of residents with responsive behaviours.

The DOC was asked to provide the Licensee's policies and procedures staff were to follow in relation to the management of residents with responsive behaviours and in response the DOC provided a seven page document titled "Responsive Behaviours", identified as NDM-lll-225 with a reviewed date of September 2015, and a one page document identified as "Appendix E: Acute Responsive Behaviour Management-Screening Decision", which was dated January 2017. The DOC confirmed that these were the only documents that related to the management of responsive behaviours.

A review of the documents provided, identified that under the procedure staff were directed to identify the causes and triggers, however the documents did not identify written approaches to accomplish this direction.

During an interview with the DOC, they were asked to explain the process/procedure that staff were to follow in order to identify possible triggers for

responsive behaviours demonstrated by residents. They responded by saying that staff document in a section of the computerized clinical record. Following a review of the section of the computerized clinical record identified, they acknowledged that the format for documenting responsive behaviours would not facilitate the identification of possible triggers for behaviours. The DOC indicated that to their knowledge home licensee did not have a documentation tool that would assist in the identification of possible triggers for responsive behaviour.

During an interview with the DOC, the above noted documents were reviewed and the DOC confirmed that the written directions for staff do not provide direction on how they are to determine the possible triggers for responsive behaviours and they verified that they were not aware of a behavioural assessment being used in the home.

The DOC and documents provided by the home verified that the licensee did not have written approaches to care that would identify possible triggers for responsive behaviours demonstrated by residents. (129) [s. 53. (1) 1.]

2. The licensee failed to ensure that at least annually the matters referred to in O. Reg. 79/10, s. 53(1) were evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The following matters referred to in O. Reg. 79/10, s. 53(1) were to be evaluated annually:
1. Written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other.
2. Written strategies, including techniques and interventions, to prevent, minimize or respond to the responsive behaviours.
3. Resident monitoring and internal reporting protocols.
4. Protocols for the referral of residents to specialized resources where required

The licensee failed to ensure the 2017 annual review of the management of responsive behaviours included an evaluation of the above noted matters.

The licensee provided a document titled "Quality Management-LTC Program/Committee Evaluation Tool" and verified it was the documentation of the 2017 annual evaluation of responsive behaviours. The document was a generic

tool that had been used for all committee and program evaluations and did not identify the specific matters that were to be evaluated related to responsive behaviours.

A review of the above noted document indicated there were no notes made on the document that indicated the matters that were required to be evaluated or updated were evaluated or updated. During an interview with the Administrator in October 2018, they reviewed a binder that contained information for all the committee and program evaluations and verified that there was no evidence that the matters referred to in O. Reg. 79/10, s. 53(1) were reviewed, evaluated or updated for 2017. [s. 53. (3) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that written approaches to care, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, whether cognitive, physical, emotional, social, environmental or other are developed and to ensure hat at least annually the matters referred to in O. Reg. 79/10, s. 53(1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to be implemented voluntarily.

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including, identify factors that would potentially trigger such altercations and failed to identify and implement interventions.

The licensee submitted an identified number of Critical Incident System (CIS) reports to the Director that related to resident to resident altercations.

A review of the clinical notes documented by registered staff relate to the altercations verified that the incidents occurred and that an identified resident continued, both before and after the incidents to initiate altercations with co-residents.

The identified resident's clinical record was reviewed for a period of time both before and after each of the identified number of incidents.

During an interview with the DOC, they were asked to explain the process used in the home to identify potential behavioural triggers for residents who demonstrated responsive behaviours. They responded to this question by indicating that PSW staff document behaviours in the computerized record and after a review of the format available in the computerized record for recording residents behaviour, acknowledged that the format would not support the identification of potential triggers for behaviours demonstrated. The DOC said that to their knowledge the home did not have a system or process for identifying possible triggers for

behaviours demonstrated by residents.

During an interview with the DOC, they were asked what steps had been taken to minimize altercations between the identified resident and co-residents. The DOC reviewed the care directions for staff who provided direct care to residents and indicated that based on the care directions in the written plan of care, there were no steps being taken to minimize or prevent the identified resident from initiating altercations with co-residents.

Following a review of the clinical record, the Inspector noted Behavioural Support Ontario (BSO) notes which directed the reader to "see recommendation list". During an interview with staff, they were asked to provide the recommendation list that BSO indicated. Staff did not know where a recommendation list would be or what information may be on the recommendation list.

At the time of this inspection the DOC was unable to provide any evidence that recommendations for care made by BSO staff had been included in the care directions for staff who provided care to resident

During an interview with the DOC they confirmed that there was no one in the home who co-ordinates the implementation of the strategies for the management of responsive behaviours.

The DOC, RN #136 and the identified residents clinical record confirmed that steps had not been taken to identify possible triggers for the responsive behaviours demonstrated, no interventions had been implemented to minimize altercations and potentially harmful interactions with co-residents continued. (129)

Please note this area of non-compliance was identified during CIS inspections log #026190-18, #027073-17, #020564-17 and #025138-18. [s. 54.]

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 factors are identified that could potentially trigger an altercation and interventions are identified and implemented, to be implemented voluntarily.

WN #22: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 57. Powers of Residents' Council

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that a written response was provided back to the Residents' Council within 10 days of being advised of concerns or recommendations made by the council.

The meeting minutes were reviewed for the Residents' Council for meetings held from January to August, 2018.

The Residents' Council raised the following concerns or recommendations at their council meeting.
January 2018 – wait times for personal care, wait times for assessment by Registered Dietitian (RD).
March 2018 – PSW staffing shortages, recommendations for programs.
April 2018 – PSW staffing shortages, missed baths, missing items, dietary.
May 2018 – Continence care, PSW shortages, staff approach, housekeeping, lack of programs.
In an interview with the Programs Manager, it was confirmed that the Residents' Council had not been provided a written response after they advised the home of their concerns or recommendations in January, March, April and May 2018.

In August 2018, concerns were brought forward by the council related to the management of responsive behaviours, maintenance, PSW shortages, personal care not being provided, and missing items. A written response was provided by the DOC on an identified date in September 2018. In an interview with the Programs Manager in September 2018, it was confirmed the response was not provided within 10 days of Residents' Council advising the home. [s. 57. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure a written response is provided to the Residents' Council within 10 days of being advised or concerns or recommendations made by the council, to be implemented voluntarily.

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 63. s. 63. If invited by the Residents' Council or the Family Council, the licensee shall meet with that Council or, if the licensee is a corporation, ensure that representatives of the licensee meet with that Council. 2007, c. 8, s. 63.

Findings/Faits saillants :

1. The licensee failed to ensure that when invited by the Residents' Council or the Family Council they met with that Council or, if the licensee was a corporation, ensured that representatives of the licensee meet with that council.

A) Residents' Council meeting minutes were reviewed from January to August 2018 and the following was documented:
- January 2018, "again residents want to invite DOC to next meeting".
- March 2018, "residents questioning why DOC is not in attendance, the council would like to speak with her, officially meet her; have some general questions they would like to ask".
- April 2018, DOC was invited but was only given two days notice so could not come. In future the DOC will be invited in a more timely fashion.
- May 2018, DOC was given a written invitation in April 2018.

In an interview with the Programs Manager, it was confirmed that Residents' Council meetings took place in January, March, April, May, June, July and August, 2018, and that the DOC was not present for any meetings and no other management representative was sent on their behalf. It was confirmed the council did not receive a response from the formal invitation that was sent to the DOC requesting them to attend their meeting in April 2018. In an interview with the Administrator, it was confirmed that the home failed to respond or meet with the Residents' when invited between January and August, 2018. (583)

B) The June 2018, Family Council meeting minutes were reviewed and it identified that the council was looking for answers to some questions that the council had raised and wondered if the licensee would better be able to address them.

In an interview with family council members it was identified that the licensee was invited for the June 2018 meeting but was unable to attend. It was confirmed that the licensee had not attended any meetings to date and that the last meeting was in September 2018.

In an interview with the licensee in September 2018, it was identified that the licensee was invited to attend a Family Council meeting, prior to the June 2018 meeting. In an interview with the licensee that was invited to attend council, it was shared that they were unavailable to meet with the Family Council in October or November 2018 and it was confirmed that no attempts had been made to ensure that another representative of the licensee attend. (583) [s. 63.]

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 when invited, the licensee meets with licensee meets with Residents' and Family Council, to be implemented voluntarily.

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 68. Nutrition care and hydration programs

Specifically failed to comply with the following:

s. 68. (2) Every licensee of a long-term care home shall ensure that the programs include,
(a) the development and implementation, in consultation with a registered dietitian who is a member of the staff of the home, of policies and procedures relating to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(b) the identification of any risks related to nutrition care and dietary services and hydration; O. Reg. 79/10, s. 68 (2).
(c) the implementation of interventions to mitigate and manage those risks; O. Reg. 79/10, s. 68 (2).
(d) a system to monitor and evaluate the food and fluid intake of residents with identified risks related to nutrition and hydration; and O. Reg. 79/10, s. 68 (2).
(e) a weight monitoring system to measure and record with respect to each resident,
(i) weight on admission and monthly thereafter, and
(ii) body mass index and height upon admission and annually thereafter. O. Reg. 79/10, s. 68 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the organized program of nutritional care and dietary services included a weight monitoring system to measure and record with respect to each resident, weight on admission and monthly thereafter, and height upon admission and annually thereafter.

While collecting resident care data during stage one of the Resident Quality Inspection, it was noted that monthly measurements of resident's weight had not been consistently recorded and yearly measurements of resident's height had not been consistently recorded.

Ten residents clinical records were reviewed and it was note that three of 10 resident's weights had not been recorded as measured on a monthly basis.
-Resident #022's weights had not been recorded for the months on May, June and July 2018.
-Resident #057's weights had not been recorded for the month of February and April, 2018.
-Resident #056's weights had not been recorded for the month of April and May 2018.

Ten residents clinical records were reviewed and it was noted that six of 10 resident's height had not been recorded as measured on an annual basis.
-Resident #022's height was monitored and documented in 2016 and no further record of the resident's height had been made.
-Resident #040, #021, #058 and #056's heights was monitored and documented in 2015 and no further record of the resident's height had been made.
-Resident #043's height was monitored and documented in May, 2017 and no further record of the resident's height had been made.

During an interview with the DOC they reviewed clinical records and confirmed that staff had not measured and recorded resident's height and weight in accordance with the requirements. [s. 68. (2) (e)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the Nutrition and Hydration programs interventions to mitigate and manage hydration risk are implemented and to ensure the weights are measured and recorded monthly and heights are measured and recorded annually, to be implemented voluntarily.

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily; O. Reg. 79/10, s. 71 (3).
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and O. Reg. 79/10, s. 71 (3).
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident was offered a minimum of a snack and beverage in the afternoon.

On an identified date during the inspection, an observation was completed of a unit at an identified time. Resident #002 and #004 were observed to be in the hallway unsupervised with unfinished and spilt beverages and snacks and were observed to be in need of feeding assisstance.

A tour was complete of the floor and it was noted that a number of snacks and beverages were unfinished at resident bedsides in the home.

An interview was completed with DA #139 it was shared the snack cart came back to the kitchen from an identified floor and beverages and regular snacks

were distributed but some modified texture and special snacks were returned on the cart.

In an interview with PSW #119 and #132 on the day of the observation, it was shared the afternoon snacks and beverages were handed out but the staff were unable to provide feeding assistance to residents that required assistance with eating due to short staffing. It was confirmed with the Administrator, that the home did not have all scheduled PSW's on the floor. It was confirmed that residents on the identified floor who required feeding assistance were not offered assistance and therefore were not offered an afternoon beverage or snack. (583)

Please note that this area of non-compliance was identified during Complaint inspection, log #021058-18. [s. 71. (3)]

2. The licensee has failed to ensure that the planned menu items were offered and available at each meal and snack.

A) A complainant voiced a concern to the LTCH Inspector that the resident was on a therapeutic diet required due to their medical diagnosis but it did not provide for much variety.

On an identified date during the RQI, a meal service was observed. Resident #050 was not asked which menu item they preferred; and staff provided an entree. In an interview with PSWs #107 and #160, they indicated that the resident was not offered a choice that day and that they were only provided with one option from the kitchen, which was the case most days. In an interview with dietary staff #139 and #142, they indicated that only one option was provided for the resident each day. The dietary staff also confirmed that there was not a second choice available on the day of the observation.

A review of the home's therapeutic planned menu for the three-week menu cycle included a variety of items. In an interview with the dietary staff it was indicated that these options were not usually available and a tour of the kitchen confirmed this.

In an interview with the Nutrition Manager and RD, they acknowledged that there were not two choices at the lunch service for this resident as well as no specialized items for the resident as per the planned menu. The planned therapeutic menu items were not available in the home for this resident. (586)

B) On an identified date during the inspection, a complainant voiced a concern to the LTCH Inspector that veal was on the planned menu for supper the previous night; however, turkey was served instead. The complainant indicated that the other option was chicken, therefore two poultry options were served.

The home's menu was reviewed which confirmed veal and chicken were on the planned menu.

In an interview with dietary staff #142, they confirmed that veal was on the menu but it was not prepared because there was none in the building. They confirmed that this was not ordered. This was also confirmed by the NM. (586)

C) Inspector #583 was approached by a complainant on an identified date because there was not a choice for dessert that day. In an interview with PSW #110 who was at the it was confirmed that a number of residents were only offered gelatin dessert as there were no servings of rhubarb left. It was confirmed the planned dessert items were not offered and available in an identified dining room during the meal service. (586)

D) Resident #006's was assessed to be at nutritional risk, and had an individualized menu developed by the RD which included specified intervention at identified meals.

During a meal service observation on two separate dates during the inspection, the resident was not offered their intervention.

E) Resident #041 was assessed to be at nutrition risk. An individualized menu was developed by the RD mitigate and manage the risk which included specified interventions.

Resident #041 was observed during a meal service on an identified date and interventions were offered.

An interview was completed with the RD, it was confirmed that resident #041's planned menu items were not offered. (583) [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure each resident is offered a snack and beverage in the afternoon and to ensure that the planned menu items are available at meals and snack, to be implemented voluntarily.

WN #26: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 75. Screening measures

Specifically failed to comply with the following:

s. 75. (2) The screening measures shall include criminal reference checks, unless the person being screened is under 18 years of age. 2007, c. 8, s. 75. (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that criminal reference checks were conducted prior to hiring the staff member.

Staff #124 was disciplined for an incident. A review was completed of the employee's file. A criminal reference check was not available in staff #124's employee file. The Administrator confirmed that staff #124 did not have a criminal reference check on file.

A review was completed of an additional three employee files that had been more recently hired and on additional staff member did not have a criminal reference check in their employee file, which was confirmed by the DOC.

Please note this non-compliance was identified during CIS Inspection log #002043-18. [s. 75. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that criminal reference checks are conducted prior to hiring the staff member., to be implemented voluntarily.

WN #27: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (3) The licensee shall seek the advice of the Residents' Council and the Family Council, if any, in developing and carrying out the survey, and in acting on its results. 2007, c. 8, s. 85. (3).

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to seek the advice of the Residents' Council and the Family

Council, in developing and carrying out the satisfaction survey, and in acting on its results.

In an interview with the Administrative Assistant, it was identified that the satisfaction surveys for 2018 started being sent out in January 2018, and the final survey results for last year were received in December 2017.

The meeting minutes were reviewed for the Residents' and Family Council for meetings held from January to July 2018. There was no documentation in the minutes that the licensee sought out any advice from the council's related to the satisfaction surveys. In an interview with Programs manager in September 2018 and the President of Family Council in September 2018, it was shared when asked by Inspector #583 that councils were not given an opportunity to provide advise related to the satisfaction surveys.

In an interview with the Administrator it was confirmed that the Residents' Council and Family Council were not given an opportunity to provide input in the developing or carrying out of the 2018 satisfaction survey, nor were they given an opportunity to act on the results of the 2017 satisfaction survey. It was confirmed that the licensee did not seek the Councils advice in relation to the satisfaction survey. [s. 85. (3)]

2. The licensee failed to ensure that, the results of the satisfaction survey were documented and made available to the Residents' Council and the Family Council.

In an interview with the Administrative Assistant on, it was identified that the satisfaction surveys for 2017 were completed in December 2017.

The meeting minutes were reviewed for the Residents' and Family Council for meetings held from January to July 2018. There was no documentation in the minutes that the licensee shared the results of the 2017 survey. In an interview with Programs manager in September 2018 who was the appointed assistant the Residents' Council and the President of Family Council in September 2018, it was shared that the two councils had not been provided any information about the results of the 2017 satisfaction survey.

In an interview with the Administrator, it was confirmed the home failed to provide the Residents' Council and the Family Council the documented results of the

2017 satisfaction survey. [s. 85. (4) (a)]

3. The licensee failed to ensure that, the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey were documented and made available to the Residents' Council and the Family Council.

In an interview with the Administrative Assistant in September 2018, it was identified that the satisfaction surveys for 2017 were completed in December 2017.

The meeting minutes were reviewed for the Residents' and Family Council for meetings held from January to July 2018. There was no documentation in the minutes that any information related to the results of the 2017 survey had been shared with the Residents' Council or Family Council. In an interview with Programs manager on September 2018 who was the appointed assistant the Residents' Council and the President of Family Council in September 2018, it was shared that the two councils had not been provided any information about the actions the licensee had taken to improve the home based on the results of the 2017 satisfaction survey.

At the time of the inspection no documentation could be found of the actions that the licensee took to improve the long-term care home and the care, services, programs and goods based on the results of the 2017 survey. In an interview with the Administrator in September 2018, it was confirmed the home failed share with the Residents' and Family Council, what action was taken to improve the home based on the 2017 results of the satisfaction survey. [s. 85. (4) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the licensee seeks the advice of Residents' and Family Council in developing and carrying out the survey and in acting on its results and to ensure the results of the survey and the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the councils, to be implemented voluntarily.

WN #28: 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).

Findings/Faits saillants :

1. As part of the organized program of housekeeping under clause 15 (1) (a) of the Act, the licensee failed to ensure that procedures were developed and implemented for cleaning of the home, specifically portable window air conditioning units and windows.

During a tour of the home on two identified dates in September and October 2018, air conditioning units located in the small and large dining rooms on both first and second floors were observed to have a black substance coating the interior of the air supply grill. The substance was suspected to be mould when touched. Other units were located in resident room windows over the summer and had been removed in October 2018. The units were sitting on the floor awaiting pick-up from families.

Housekeeper #167 reported that they did not clean the interior of the units and the maintenance person confirmed that the units were not deep cleaning in any way.

According to the manufacturer's directions for basic portable air conditioners, the units should be disassembled to get to the fins and coils annually and other components such as filters and condensate pan more frequently to adequately clean dust and mold accumulation.

No policy or procedure was developed to include portable window air conditioners for cleaning and whether the licensee was responsible for cleaning the units that they did not own and were installed in resident rooms. The manager of housekeeping/laundry services was not aware of any procedures created specifically for cleaning air conditioners.

According to the licensee's policy and procedure "MDM-III-60" entitled "Air Conditioners", dated June 2004, all air conditioners throughout the facility that were of the portable, window installation type would be checked for proper operation prior to seasonal use. No other direction was provided.

2. During a tour of the home throughout the inspection period, the windows in the home, which were double sliders with four glass sashes, were not clean. The area between the exterior and interior sashes was full of accumulated dust and insects on many of the windows, especially on one side of the building.

The licensee's policy HDM-III-085 entitled "Window Glass Cleaning" did not include a frequency of when the windows were to be cleaned, who would clean what parts of the windows and how the windows would be dismantled if necessary to access all parts of the window.

According to the home's maintenance person, a company was hired in early 2018, to clean the windows, however not all of the windows were cleaned. According to housekeeper #167, the area between the window sashes was not cleaned, only the glass on the inside and the trim.

The licensee failed to ensure that procedures were developed and implemented for cleaning portable window air conditioning units and windows in the home. [s. 87. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented for cleaning of the home, specifically portable window air conditioning units and windows, to be implemented voluntarily.

WN #29: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

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

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(h) immediate action is taken to reduce the water temperature in the event that it exceeds 49 degrees Celsius; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(j) if the home is using a computerized system to monitor the water temperature, the system is checked daily to ensure that it is in good working order; and O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. As part of the organized program of maintenance services under clause 15 (1)

(c) of the Act, the licensee failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance.

During the inspection, the condition of the flooring material was observed to be in poor condition in but not limited to an identified number of resident rooms and a lounge on the second floor. Numerous square vinyl tiles were lifting and/or cracked. The tiles appeared dull and did not have the same amount of wax or sealant as the same flooring material in the corridors. The corridor tiles appeared in good condition. The maintenance person confirmed that the flooring material in resident bedrooms and lounges did not have the same amount of wax on them as the corridors and stated that the wax played a large role in protecting the tiles from drying out and subsequently cracking.

The licensee's policy MDM-III-100 entitled "Interior and Exterior Finishes" dated June 2004, required that a monthly inspection be conducted of all interior and exterior walls, ceilings and floor areas, windows and door surfaces. The results were to be recorded on a monthly inspection report. The inspection report for the last 12 months could not be provided as the maintenance person acknowledged that they did not have time to complete it.

The floor care program as per policy HDM-111-090 entitled "Stripping and Re-waxing Floors", required the maintenance department to strip and re-wax the floors twice yearly or more often as required. However, the maintenance person stated that no time had been allocated to conduct the required routine over the last two years with the exception of corridors. An external contractor to complete the work was not employed to complete the task.

No plans were in place at the time of inspection to address the condition of the identified flooring condition.

The licensee therefore failed to ensure that there were schedules and procedures in place for routine, preventive and remedial maintenance related to the flooring material. [s. 90. (1) (b)]

2. The licensee failed to ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49C (degrees Celsius).

According to the licensee's policy and procedure MDM-III-75 entitled "Water

Temperature", dated October 2007, no direction was provided as to what course of action nursing staff, maintenance staff or administration staff would need to take when water temperatures exceeded 49C.

According to water temperature logs maintained by registered staff on the first floor for identified dates in September and October 2018. No notes or follow up comments were made on the temperature logs. The maintenance person was not aware of the exceedances. The administrator, when asked about possible follow up actions that were available, identified several, however the information was not available to staff in the policy.

The licensee failed to ensure that procedures were developed and implemented to ensure that immediate action was taken to reduce the water temperature in the event that it exceeded 49C (degrees Celsius). [s. 90. (2) (h)]

3. The licensee failed to ensure that procedures were developed and implemented to ensure that, if the home was not using a computerized system to monitor the water temperature, that the water temperature was monitored once per shift in random locations where residents had access to hot water.

According to the licensee's policy and procedure "MDM-III-75" entitled "Water Temperature", dated October 2007, hot water temperatures were to be taken daily by registered staff. No information was included as to whether or not the home was equipped with a computerized system to monitor water temperatures. The maintenance person confirmed during the inspection that their hot water system was not equipped with a computerized system and that staff had to take water temperatures manually using a probe thermometer.

According to water temperature logs reviewed in October 2018, and maintained by registered staff, water temperatures were taken by the registered staff on the first floor only. For the months of September and October 2018, water temperatures were taken in random resident washrooms once every 24 hours. Temperatures were not documented for six of the dates reviewed in 2018. No temperatures were taken in dining rooms where hand sinks were also accessible to residents.

The licensee failed to ensure that the water temperature was monitored once per shift in random locations where residents had access to hot water. [s. 90. (2) (j)]

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 there are schedules and procedures in place for routine, preventive and remedial maintenance, to be implemented voluntarily.

WN #30: The Licensee has failed to comply with O.Reg 79/10, s. 98. Every licensee of a long-term care home shall ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence. O. Reg. 79/10, s. 98.

Findings/Faits saillants :

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

A) On an identified date, a Critical Incident System (CIS) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) following a call to the After Hours Pager, reporting an incident of alleged staff to resident neglect.

The home's investigations notes contained a CIS Incident Checklist. The checklist had a check box stating "Call Police-if applicable". The box had been checked "not applicable".

During interview with the DOC, they confirmed that the police had not been notified in regards to the witnessed neglect of resident #009 as they did not believe it constituted a criminal offense.

On an identified date, a CIS report was submitted to the MOHLTC following a call to the After Hours Pager.

During interview with the DOC, they confirmed that the police had not been notified in regards to the alleged neglect of the identified residents as they did not believe it constituted a criminal offense.

B) The licensee failed to notify the appropriate police force following four incidents of abuse that involved resident #004, resident #027 and resident #038, that the home reported to the Ministry of Health and Long Term Care.

On four identified dates the licensee submitted a CIS to the Director related to resident to resident abuse.

During an interview with the Administrator, they reviewed the above noted CIS documentation and verified that there was no documentation on the CIR's to indicate that the appropriate police force was immediately notified when the licensee reported to the Director related to alleged abuse of resident #004, resident #027 and resident #038.

A review of the clinical notes completed during this inspection related to the above noted incidents confirmed that there was no documentation in the clinical notes to indicate that police were not going to be contacted or that police were contacted.

At the time of this inspection the DOC was unable to provide any documentation to verify that police were contacted immediately following the licensee's report to the Director. (129) [s. 98.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the appropriate police force is immediately notified of any alleged, suspected or witnessed incident of abuse or neglect of a resident that the licensee suspects may constitute a criminal offence, to be implemented voluntarily.

WN #31: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and recommend any changes necessary to improve the system.

A review of the annual evaluation of the medication management system that the licensee completed in November 2017, listed the staff who attended the evaluation were the Administrator, DOC, ADOC, and food service manager. In an interview with the pharmacist in October 2018, confirmed they did not attend the annual evaluation of the medication management system in November 2017. In an interview with the former Administrator at the home in October 2018, confirmed that the Medical Director, the pharmacist and the RD did not attend the annual evaluation of the medication management system to evaluate the effectiveness of the medication system and recommend any changes necessary to improve the system. [s. 116. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that an interdisciplinary team, which must include the Medical Director, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and recommends any changes necessary to improve the system, to be implemented voluntarily.

WN #32: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that drugs stored in a medication cart were secure and locked.

While completing a tour on an identified date during the inspection, at an identified time, it was noted by the Inspection Manager and Inspector #583 that the medication cart located in the hallway was unlocked and unattended. RPN #140 came out of a resident's room where they were providing care and confirmed drugs in the medication cart were not secure as the cart had been left unlocked. [s. 129. (1) (a)]

Additional Required Actions:

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

WN #33: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee has failed to ensure that the quality improvement and utilization review system required under section 84 of the Act complied with the requirements listed in the Regulations.

A review of the home's Continuous Quality Improvement (CQI) binder included meeting minutes up to December 2017. There were no meeting minutes identified for 2018. In an interview with the Administrator, they confirmed that the previous Administrator had put the meetings on hold with the plan to recommence them; however, this had not been done. [s. 228.]

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 quality improvement and utilization review system required under section 84 of the Act complies with the requirements listed in the Regulations, to be implemented voluntarily.

WN #34: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (2) At a minimum, the policy to promote zero tolerance of abuse and neglect of residents,
(a) shall provide that abuse and neglect are not to be tolerated; 2007, c. 8, s. 20 (2).
(b) shall clearly set out what constitutes abuse and neglect; 2007, c. 8, s. 20 (2).
(c) shall provide for a program, that complies with the regulations, for preventing abuse and neglect; 2007, c. 8, s. 20 (2).
(d) shall contain an explanation of the duty under section 24 to make mandatory reports; 2007, c. 8, s. 20 (2).
(e) shall contain procedures for investigating and responding to alleged, suspected or witnessed abuse and neglect of residents; 2007, c. 8, s. 20 (2).
(f) shall set out the consequences for those who abuse or neglect residents; 2007, c. 8, s. 20 (2).
(g) shall comply with any requirements respecting the matters provided for in clauses (a) through (f) that are provided for in the regulations; and 2007, c. 8, s. 20 (2).
(h) shall deal with any additional matters as may be provided for in the regulations. 2007, c. 8, s. 20 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that at a minimum, the policy to promote zero tolerance of abuse and neglect of residents shall contain an explanation of the duty under section 24 to make mandatory reports.

The licensee's "Abuse and Neglect - ADM-II-245" policy, effective August 2015, stated, "Administrator/Designate: Immediately, (within 24 hours) by phone by calling the Duty Inspector on the Ministry ACTION line."

The Administrator identified that the wording, "within 24 hours" did not direct staff to immediately report, and confirmed that the homes policy did not contain an explanation of the duty under section 24 to make mandatory reports. The Administrator also confirmed that the home's policy had not been updated as per the July 2018 memo from the Ministry of Health and Long Term Care (MOHLTC) to all Long Term Care (LTC) homes in regards to the new after hour's ACTION line phone number. [s. 20. (2)]

WN #35: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 23. Licensee must investigate, respond and act

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A) A CIS was submitted to the Director on an identified date, regarding suspected neglect of an identified number of residents. A review was conducted of the licensee's investigation notes. The DOC confirmed that the results of the investigation were not reported to the Director.

The licensee failed to ensure the results of every investigation were reported to the Director.

B) A CIS was submitted to the Director on an identified date, regarding improper wound assessment and care. A review was conducted of the licensee's investigation notes. At the time of this inspection the DOC was unable to provide the final results of the outcome of the investigation and confirmed they did not amend the CIS to the Director to include the results of investigation. (506) [s. 23. (2)]

WN #36: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure a person who had reasonable grounds to suspect that abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident was immediately reported to the Director.

Staff did not immediately report to the Director three incidents of abuse that resulted in injury to resident #027, resident #004 and resident #038.

While completing a Critical Incident System (CIS) Inspection which had been identified as Abuse/Neglect, it was noted that the home reported the incident to the Director through the CIS system, four days later.

During an interview with the Administrator, they reviewed the information contained in the CIS report and confirmed that this incident was reported to the Director four days after the incident and staff had not complied with the requirement to immediately report abuse.

2. While completing a (CIS) Inspection which had been identified as Abuse/Neglect, it was noted the home reported the incident to the Director three days after the incident occurred.

During an interview with the Administrator, they reviewed the information contained in the CIS report and confirmed that this incident was reported to the Director three days after the incident and staff had not complied with the requirement to immediately report abuse.

3. While completing a (CIS) Inspection which had been identified as Abuse/Neglect, it was noted the home reported the incident to the Director 22 hours after the incident occurred.

During a review of the CIS documentation it was confirmed that staff completing the CIS, specifically indicated that the Ministry of Health and Long Term Care's after hour pager was not contacted about these incidents.

During an interview with the Administrator, they reviewed the information contained in the CIS and confirmed that this incident was reported to the Director 22 hours after the incident and staff had not complied with the requirement to immediately report abuse. [s. 24. (1)]

WN #37: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that a care conference of the interdisciplinary team providing a resident's care was held at least annually after admission to discuss the plan of care and any other matters of importance to the resident and his or her substitute-decision maker, if any.

A review of resident #004's clinical health record included an Annual Summary Conference form. The form indicated that RN #136 was the only person in attendance at the resident's annual care conference. In an interview with the RN, they confirmed that they were the only person present at the care conference, and indicated that they often have trouble getting interdisciplinary team members to attend resident care conferences. Resident #004's care conference did not include the interdisciplinary team providing the resident's care. [s. 27. (1) (a)]

2. The licensee has failed to ensure that a record was kept of the date, the participants and the results of the six-week and annual care conference.

A complaint was brought forward to the LTCH Inspector indicating that resident an identified resident's care conference was not interdisciplinary. In an interview with RN #125, they confirmed that care conferences were documented in the residents clinical records, as well as Annual Summary Conference forms in the hard copy chart which include the signatures of those who attended the conference. A progress note, written by RN #125, documented the resident's six-week care conference; however, this did not include the participants of the care conference. There was no Annual Summary Conference documented located in the resident's hard copy chart. A record was not kept of the participants of the care conference.

Please note that this area of non-compliance was identified during Complaint inspections, log #023309-18 and #026275-18. [s. 27. (1) (c)]

WN #38: The Licensee has failed to comply with O.Reg 79/10, s. 32. Every licensee of a long-term care home shall ensure that each resident of the home receives individualized personal care, including hygiene care and grooming, on a daily basis. O. Reg. 79/10, s. 32.

Findings/Faits saillants :

1. The licensee failed to ensure that each resident of the home received individualized personal care, including grooming, on a daily basis.

According to PSWs #107 and #146, when a resident was bathed, they were to have their facial hair shaved as part of the bath as per the licensee's protocol for bathing. A complainant voiced a concern to the LTCH Inspector that an identified resident was not being shaven daily, as per their documented plan of care. Observation of the resident on an identified date during the RQI revealed that they were not clean-shaven. In an interview with PSW #146, they indicated that the resident had their bath that morning but had not been shaved, as per the licensee's expectation. PSW #157, who provided the bath, confirmed that they did not shave the resident. [s. 32.]

WN #39: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee failed to ensure that each resident in the home received oral care to maintain the integrity of the oral tissue that included, mouth care in the morning and evening and the physical assistance or cueing to help a resident who could not brush their own teeth.

During an interview with a complainant, it was shared that they were concerned that an identified resident was not getting the assistance they required with oral care. The resident's teeth were observed and required oral care. Resident #050 shared that no one assisted them with oral care that morning.

The plan of care identified resident #050 required extensive assistance from one staff with oral care and directed staff to provide assistance as required.

A second observation was completed and resident #050 shared they did not get assistance with their teeth and their teeth appeared unclean. The oral care task report was reviewed and there was no documentation that oral care was provided or the resident refused. Resident #050's labelled tooth brush was observed with the DOC. It was confirmed the tooth brush had hardened clumps of dried tooth paste embedded in the bristles and the brush was dry and yellowed in color. The DOC confirmed the brush appeared not to have been used for a period of time.

A oral care report was reviewed and an identified number of days had no documentation that oral care had been completed.

Through interviews with the resident, observations and a review of the oral care provided documentation it was confirmed resident #050 did not receive the assistance they required to brush their teeth. [s. 34. (1) (b)]

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was dressed appropriately, suitable to the time of day and in keeping with his or her preferences, in his or her own clean clothing.

A) On an identified during the inspection in the late afternoon, seven residents were observed by the LTCH Inspector to be wearing their night time attire. An interview with PSW #134 and #135, confirmed that the above residents' plans of care did not include being placed in their night time attire prior to the dinner meal as the residents' preferences. The PSW's also confirmed that the residents were placed in their night time attire at this time because they were short PSW's to help with care later in the evening.

B) On an identified date during the inspection, resident #043 was observed after meal service with food stains. The resident was observed again approximately three hours later, after staff had provided some required care to the resident. PSW #107 confirmed the clothing was soiled and indicated that the staff should have noticed this and assisted the resident with changing into clean clothing. [s. 40.]

WN #41: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 67. s. 67. A licensee has a duty to consult regularly with the Residents' Council, and with the Family Council, if any, and in any case shall consult with them at least every three months. 2007, c. 8, s. 67.

Findings/Faits saillants :

1. The licensee failed to ensure that they consulted with the Residents' Council at a minimum of every three months, as part of their duty to consult regularly.

The Residents' Council meeting minutes for January, March, April, May, June and July 2018, were reviewed. There was no documentation that the licensee or Management of the home, including the Administrator or Director of Care had consulted with the Residents' Council. In an interview with the President and Vice President of Residents' Council they did not recall that the home had consulted with them during this time period. An interview was completed with the Program Manager in September 2018, and it was confirmed that they were the appointed Residents' Council Assistant. The Program Manager confirmed that the licensee did not consult with the Residents' Council during the identified time period which required that the home consult with the Council a minimum of two times. [s. 67.]

WN #42: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (2) The food production system must, at a minimum, provide for, (d) preparation of all menu items according to the planned menu; O. Reg. 79/10, s. 72 (2).

s. 72. (2) The food production system must, at a minimum, provide for, (f) communication to residents and staff of any menu substitutions; and O. Reg. 79/10, s. 72 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the food production system in the home provided for the preparation of all menu items according to the planned menu.

The posted lunch menu on an identified date in September 2018, included cream of celery soup. During lunch meal service observation it was identified that no soup was served. No residents were offered the option of soup, including any canned soup. Dietary aide #101 confirmed there was no soup prepared that day but was unsure as to why that was. PSW #100 also confirmed there was no soup and said they were unsure as to why, but thought it could be due to being short-staffed in the kitchen. The Nutrition Manager confirmed that no soup was prepared or served on the identified date, according to the planned menu. [s. 72. (2) (d)]

2. The licensee has failed to ensure the food production system provided for communication to residents and staff of any menu substitutions.

The posted breakfast menu on an identified date in September 2018, included poached eggs. Breakfast meal service was observed in all dining rooms. Scrambled eggs were served to the residents rather than poached eggs. In an interview with dietary aide #122, they indicated that poached eggs were not served due to the home's steamer being broken. The posted menus outside of the home's five dining rooms did not include this menu change. The menu substitutions were not communicated to the residents. This was confirmed by the Nutrition Manager. [s. 72. (2) (f)]

WN #43: 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).

Findings/Faits saillants :

1. As part of the organized program of laundry services under clause 15 (1) (b) of the Act, the licensee failed to ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

Various staff who worked in the home were not aware of any forms that should be completed or procedures they should follow if a family member or resident complained about lost items with the exception to try and look for the items.

The licensee's policy LDM-IV-010 entitled "Resident Clothing", dated June 2018, did not include any direction for staff as to the process of handling complaints for lost items, how the complaint would be documented, who would conduct the search, what areas would be searched (resident rooms, laundry) and how to follow up with the complainant. The policy directed staff to place articles with no labels into a lost and found cupboard. It did not include the information that was provided by the laundry aide regarding the lost and found rack located outside of the laundry room, how long the items would be stored for and how staff could promote staff and families to identify the lost items, No information was included about the off-site laundry facility, what type of linens were washed at the facility, how often and why items could not be retrieved once sent out.

The licensee failed to ensure that procedures were developed and implemented to ensure that there was a process to report and locate residents' lost clothing and personal items.

Please note this non-compliance was identified during Complaint Inspection log #021067-18. [s. 89. (1) (a) (iv)]

WN #44: The Licensee has failed to comply with O.Reg 79/10, s. 99. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of every incident of abuse or neglect of a resident at the home is undertaken promptly after the licensee becomes aware of it;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 20 of the Act to promote zero tolerance of abuse and neglect of residents, and what changes and improvements are required to prevent further occurrences;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes and improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes and improvements were implemented is promptly prepared. O. Reg. 79/10, s. 99.

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the analysis undertaken of every incident of abuse or neglect of a resident at the home were considered in the evaluation, and that the annual evaluation of the policy to promote zero tolerance included the names of the persons who participated in the evaluation, and the date the changes and improvements were implemented.

Inspector #536 spoke with the former Administrator of the home. When asked by the Inspector why their name was the only name on the evaluation they confirmed that they had completed the evaluation on their own.

When asked by the Inspector if an analysis was undertaken for every incidents of abuse or neglect of a resident of the home and was that analysis considered in the evaluation completed, they confirmed that an evaluation had been completed for their Accreditation however, those results were not considered in the annual evaluation completed.

The former Administrator also confirmed that the home's "Outstanding Issues/Goals for the Coming Period i) face to face orientation with new employee's, ii) move staff who intimidate other staff and discipline as required," did not identify the date the changes and improvements were implemented. [s. 99. (e)]

WN #45: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
3. A response shall be made to the person who made the complaint, indicating,
i. what the licensee has done to resolve the complaint, or
ii. that the licensee believes the complaint to be unfounded and the reasons for the belief. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every written complaint made to the licensee or a staff member that concerned the care of a resident was investigated and resolved where possible and failed to ensure a response that complied with paragraph 3 was provided within 10 business days.

In an interview with an identified complainant, it was shared that they brought forward concerns related to care and care. Progress notes documented on an identified date, by Registered Nurse (RN) #150 identified the complainant made the RN aware of the care concerns and shared it was a formal complaint and a written complaint was sent to the Director of Care (DOC) concerning the care of the resident.

The homes complaint records were reviewed and no documented record was found related to the complaint. In an interview with the Administrator, it was confirmed the home failed to ensure that the written complaint made was investigated and that a response was provided to the person who made the complaint. [s. 101. (1) 1.]

2. The licensee failed to ensure a response was provided to the person who made a complaint concerning the care of a resident and the operation of the home, indicating, what the licensee had done to resolve the complaint.

In an interview with an identified complainant, it was shared that they brought forward multiple care concerns as well as the operation of the home on a specified date. The complaint was provided in writing and more information was shared verbally in an interview with the former Administrator.

The homes complaint records were reviewed and a response letter, was provided to the person who made the complaint acknowledging their concerns. The complainant confirmed they received acknowledgment of receipt of their complaint but did not receive a response indicating what the licensee had done to resolve the complaint. The documentation kept in the homes complaint log was reviewed and no documentation was found of any additional responses provided to the complainant. The documentation from the records were reviewed with the Administrator and it was confirmed that a response was not provided to the complainant indicating what the licensee had done to resolve the complaint. [s. 101. (1) 3.]

WN #46: The Licensee has failed to comply with O.Reg 79/10, s. 216. Training and orientation program

Specifically failed to comply with the following:

s. 216. (2) The licensee shall ensure that, at least annually, the program is evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 216 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that, at least annually, the training and orientation program was evaluated and updated in accordance with evidenced-based practices and, if there are none, in accordance with prevailing practices.

During an interview with the Administrator on October 2018, they reviewed a binder that contained the 2017 annual program evaluations and verified that the training and orientation program had not been evaluated and updated in 2017. [s. 216. (2)]

Issued on this 26th day of March, 2019 (A4)

[redacted]

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

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

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by KELLY HAYES (583) - (A4)
Inspection No. / No de l'inspection :	2018_756583_0014 (A4)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	007771-18, 007772-18, 022899-18 (A4)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Mar 26, 2019(A4)
Licensee / Titulaire de permis :	Maplewood Nursing Home Limited 73 Bidwell Street, TILLSONBURG, ON, N4G-3T8
LTC Home / Foyer de SLD :	Cedarwood Village 500 Queensway West, SIMCOE, ON, N3Y-4R4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Marci Hutchinson

To Maplewood Nursing Home Limited, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Order / Ordre :

The licensee must be compliant with s. 5 of the LTCHA, 2007.

Specifically, the licensee must:

1. Ensure all registered staff, PSWs, maintenance staff, housekeepers and laundry aides shall be informed in writing and acknowledge that they have read that they understand that residents must not have access to heat generating appliances or equipment, toxic or hazardous substances, exposed sharps, medicines and unsafe conditions.

2. Ensure both tub rooms, if equipped with towel heating equipment, shall be kept locked at all times unless directly supervised by staff.

3. Ensure all product containers that are re-filled, whereby the original product was diluted and transferred into a smaller container, must be labelled with the product identifier and any applicable precautionary statements.

Grounds / Motifs :

1. 1. The licensee failed to ensure that the home was a safe and secure environment for its residents.

A complaint was received by the MOHLTC that tub rooms were often left unlocked by employees, allowing residents to have access to disinfection products within the tub room.

During the inspection on two occasions, a tub room in the home was observed to be wide open with no staff present or in sight. Within the tub room was a towel warmer set to 65 degrees Celsius. When the surface was touched, it was very hot and the inspector could not keep their hand on the surface for more than a second without fear of receiving a burn. According to the manufacturer of the towel warmer, if set to over 43 degrees Celsius, there was a risk of burning.

In the tub room, the inspector also observed accessible concentrated tub disinfectant hooked up to the tub. The tub disinfectant was labelled as corrosive, had a high health risk and had the ability to cause digestive tract and skin burns.

The DOC, when questioned about staff leaving the tub room doors open, stated that they were aware of the issue, had addressed their concerns with staff and had been monitoring their compliance to keep the door closed and locked when not occupied by staff.

The licensee failed to ensure that the home was a safe and secure environment for its residents.

Please note that this area of non-compliance was identified during Compliant Inspection log #016668-18. [s. 5.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to residents in the home. The scope of the issue was a level 2, pattern. The home had a level 2 history as they had ongoing unrelated non-compliance. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:

1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

O. Reg. 79/10, s. 229 (10).

Order / Ordre :

(A4)
The licensee must be compliant with O. Reg. 79/10 s. 229 (10) 1 of the LTCHA.

Specifically, the licensee must:

1. In consultation with the Haldimand Norfolk Health Unit, complete an assessment to determine which residents are required to be screened and how many residents have or have not been adequately screened for TB.

2. Screen all residents for tuberculosis (TB) who have not been previously screened using the guidelines identified in the "Canadian Tuberculosis Standards, 7th edition, 2014" or as directed by the Haldimand Norfolk Health Unit.

3. Keep accurate documentation of the names of the residents who were screened, the results of the screening, the date screening was conducted, the person who conducted the screening and any other information gathered from the assessment process including all follow up action where necessary.

4. Update the policy entitled "TB screening for residents" (ICM-V-021) to include current prevailing practices as identified in the Canadian Tuberculosis Standards, 7th edition, 2014" in consultation with the Haldimand Norfolk Health Unit.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Grounds / Motifs :

1. The licensee failed to ensure that the following immunization and screening measures were in place: (4) Staff is screened for tuberculosis and other infectious diseases in accordance with prevailing practices.

Prevailing practices related to staff screening for tuberculosis can be found in a document entitled "Canadian Tuberculosis Standards, 7th edition, 2014". It includes baseline screening upon hire or placement using a two-step tuberculin skin test (TST) and recommendation for an annual TST unless the conversion rate is shown to be less than 0.5%.

A record listing the TB status of all staff in the home was requested from the DOC. No record could be produced. Identified staff members stated that they were not screened for TB before they were employed by the licensee over several years prior.

The license's "TB Screening for Staff" (ICM-IV-060) policy, dated March 2009, did not include information with the exception that a two-step skin test was to be conducted before the first day of work. No guidance was provided as to who would administer the skin test and where, follow up action for individuals who tested positive, what records were required to be produced if the staff member received TST testing elsewhere or any references to current resources and best practices.

The licensee failed to ensure that staff were screened for tuberculosis and other infectious diseases in accordance with evidence based practices. [s. 229. (10) 4.]

The severity of this issue was determined to be a level 2 as there was a potential for harm to the residents. The scope of the issue was a level 2, pattern. The home had a level 2 history as they had ongoing unrelated non-compliance. (583)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A1)

Order # / Ordre no : 003

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.
2. Residents must be offered immunization against influenza at the appropriate time each year.
3. Residents must be offered immunizations against pneumoccocus, tetanus and diphtheria in accordance with the publicly funded immunization schedules posted on the Ministry website.
4. Staff is screened for tuberculosis and other infectious diseases in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
5. There must be a staff immunization program in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.
O. Reg. 79/10, s. 229 (10).

Order / Ordre :

(A4)
The licensee must be compliant with O. Reg. 79/10, s. 229 (10) 4 of the LTCHA.

Specifically, the licensee shall complete the following;

1. In consultation with the Haldimand Norfolk Health Unit, an assessment shall be conducted to determine which employees are required to be screened and how many employees have or have not been adequately screened for TB. Those who are required to be screened and have not been screened for TB, shall be screened for tuberculosis using a two-step

tuberculin skin test (if under 65). An exception applies where documented results of a prior two-step tuberculin skin test (TST) exist, in which case a single-step TST should be given and prior TST results transcribed into the employees' health record.

2. Accurate documentation shall be kept of the names of all employees who have been screened, the results of their screening test(s), follow up action taken if positively identified with TB, who conducted the screening and the date(s) they were screened.

3. An ongoing screening program shall be established to determine whether the long term care home needs to conduct annual TST for employees (with negative baseline TSTs) involved in intermediate-risk activities in health care settings not considered low risk. Refer to the Canadian Tuberculosis Standards, 7th edition or contact the Haldimand Norfolk Health Unit for additional information on establishing the appropriate screening program for employees.

4. Update the policy entitled "TB Screening for Staff" (ICM-IV-060) to include administrative control measures such as occupational health programs incorporating skin testing of employees for latent tuberculosis infection (LTBI) after exposure and at regular intervals, access to treatment of LTBI, exclusion of employees with respiratory TB disease, facility and unit risk assessments, as well as an employee education program.

5. Provide face to face education to all registered staff regarding the updated "TB Screening for Staff" policy, epidemiologic and medical risk factors for TB, signs and symptoms of active TB disease (respiratory and non-respiratory), mechanisms of transmission, screening methods, follow up action requirements if a resident or staff member is positive after screening and any other TB related information as recommended by your local public health unit representative.

6. All remaining staff including housekeeping, laundry, dietary and maintenance staff, shall be educated as to the updated "TB Screening for Staff" policy and to respect posted signage, the use of personal protective equipment, the mechanism of TB transmission, signs and symptoms of

active TB disease and any other relevant TB related information as recommended by your local public health unit representative.

Grounds / Motifs :

(A4)
1. The licensee failed to ensure that the following immunization and screening measures were in place:

Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Prevailing practices related to resident screening for tuberculosis can be found in a document entitled "Canadian Tuberculosis Standards, 7th edition, 2014". For residents over 65 years of age, it includes a recommendation that residents undergo a history and physical examination by a physician/nurse practitioner, which would include a symptom review for active pulmonary TB disease and a chest x-ray (posterior-anterior and lateral). The document further identified that the tuberculin skin test (TST) was not reliable and difficult to interpret in older people. A baseline 2-step TST for those 65 years old and under who also belong to an identified at-risk group was recommended. Verification was made with the Haldimand-Norfolk Health Unit in October 2018, that they have adopted the standards and expect long term care homes in their region to follow the standard.

A record listing the TB status of all residents in the home at the time of inspection was requested. An identified number of residents listed on the licensee's "Immunization Tracker" for 2018 did not include information, as to a date of screening and the results. The remaining residents were screened using a TST with negative results.

The licensee's "TB screening for residents - ICM-V-021" policy, dated March 2009, did not include the most current best practices related to screening residents over 65 years of age. The policy referred to a 'two- step Mantoux (skin test)' on each resident. The policy further required that accurate documentation appear on the resident's electronic documentation under immunizations and in the interdisciplinary notes with regard to date, injection site and results of the test. In addition, the policy

direction did not include the requirement that the resident, if screened within 90 days of admission, did not need to be screened again after admission if the results were available to the licensee.

The severity of this issue was determined to be a level 2 as there was a potential for harm to the residents. The scope of the issue was a level 2, pattern. The home had a level 2 history as they had ongoing unrelated non-compliance. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A1)

Order # / Ordre no : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 229. (6) The licensee shall ensure that the information gathered under subsection (5) is analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks. O. Reg. 79/10, s. 229 (6).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 229 (6) of the LTCHA.

Specifically the licensee must:

1. A designated person with experience in infection prevention and control shall analyze daily all recorded infections related to residents and once per month, review the data to determine trends in accordance with "Best practices for Surveillance of Health Care Associated Infections in Patient and Resident Populations, 2014". The information gathered shall be documented and retained and used to determine how to reduce the incidence of infections and outbreaks in the home.

2. The rate of all infections related to residents that meet the case definitions, as outlined in the above noted document, is presented to the infection prevention and control committee on a quarterly basis.

Grounds / Motifs :

1. 2. The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

i) According to evidence based practices entitled "Testing, Surveillance and Management of Clostridium difficile in all Health Care Settings, January 2013" a

Clostridium difficile-Associated Disease (CDI) acquired within a facility is one that includes three or more loose stools within a 24 hour period, beginning at least 72 hours post admission. The incubation period [when signs and symptoms first appear] for CDI is between five and 10 days and is transmitted from the rectum to surfaces by contaminated hands. The organism can survive on surfaces for up to five months. Further, managing cases of CDI includes establishing a mechanism for counting and keeping track of the number of confirmed cases of CDI acquired within the facility according to a standardized case definition (provided for in the document) and maintaining a summary record. The infection prevention and control designate is required to review and analyze the data on an ongoing basis, to identify any clusters and the records should be submitted as a report to the Infection Prevention and Control Committee.

A review of the meeting minutes for the Infection Prevention and Control Committee for 2018, did not include a review of any CDI statistics.

During the inspection, the DOC and Administrator were requested to provide the number of confirmed cases between 2017 and October 2018, and subsequently no records and data were provided, no summary records that could be reviewed to determine if an outbreak of CDI cases had occurred and how they were managed within the home during 2017 and 2018.

ii) The licensee submitted six Critical Incident System (CIS) reports with the Ministry of Health and Long-Term Care (MOHLTC) identifying that their facility was experiencing either an enteric or respiratory outbreak between August 2017 and October 2018. The reports included basic facts such as number of residents and staff affected, the duration of the outbreak, whether cultures were taken and the results and whether any deaths occurred and any hospitalizations.

When records for five out of the six outbreaks were requested, only some of the information was available. A detailed summary report or record for each outbreak completed by the infection control designate in the home was not available. A review of the meeting minutes for the Infection Prevention and Control Committee for 2018, did not include a review of the outbreak or any associated statistics.

Information regarding the outbreaks in 2018, was acquired from the local public health unit and reviewed. According to public health outbreak summary reports for

outbreaks in December 2017, January and February 2018, which were sent to the licensee after each outbreak, failures were identified related to timely reporting, familiarity with the outbreak process (using appropriate line listing, faxing the data on a daily basis, one designated person as point of contact with the health unit), current staff immunization records, tracking the population at risk within the home and enhanced cleaning requirements.

According to the licensee's "Infection Control Surveillance- ICM-VII-010" and "Respiratory Outbreak Protocol-ICM-VIII-020" polices, effective March 2009, the DOC or designate was required to provide the health unit with an updated line listing on a daily basis, that the RNs would initiate a surveillance form, document in progress notes on every shift the presence or absence of symptoms and that the DOC or designate would gather further data for infection tracking and reporting. The policies were reflective of public health requirements for reporting, surveillance, data collection, the implementation of general infection control measures (staff cohorting, cleaning frequencies, personal protective equipment and signage, visitor precautions), communication and overall post outbreak assessment.

During the inspection, a respiratory outbreak was in effect and the DOC reported the outbreak to public health. Surveillance forms were gathered from the registered staff for review. The names of an identified number of residents with different symptoms were listed. According to public health requirements, any two residents with the same two or more symptoms should have been reported to their local public health unit to alert them of a suspect outbreak. The licensee did not initiate a report with public health until six days later, at which time they had additional residents with similar symptoms in the home.

The DOC was not aware that an identified number of residents presented with identified symptoms and had not reviewed or collected the surveillance sheets from the two separate nurse's stations for review. When requested to provide their monthly statistics for the last 12 months, identifying which infections were prevalent, the duration of the infections and any other trends, none could be provided as they were not collected.

The licensee failed to ensure that the information gathered under subsection (5) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Please note that this area of non-compliance was identified during CIS Inspection log #021199-17 and #0090992-18. [s. 229. (6)] (120)

The severity of this issue was determined to be a level 2 as there was a potential for harm to the residents. The scope of the issue was a level 2, pattern. The home had a level 2 history as they had ongoing unrelated non-compliance. (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 005

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 86. (2) The infection prevention and control program must include,
(a) daily monitoring to detect the presence of infection in residents of the long-term care home; and
(b) measures to prevent the transmission of infections. 2007, c. 8, s. 86. (2).

Order / Ordre :

(A3)
The licensee must be compliant with s.86 (2) of LTCHA.

Specifically the licensee must:

1. Ensure all urine measure hats that are not disposed of after each use, shall be cleaned and disinfected after each use and shall be stored so that they are not subject to contamination.

2. Ensure all portable fans are to be cleaned of dust and a written cleaning schedule developed to ensure that fans are cleaned as often as necessary to keep them free of accumulated dust. The licensee shall establish in writing who is responsible for cleaning and maintaining resident owned fans.

3. Develop and implement a policy related to the management and use of portable or fixed supplemental ventilation units (table top, stand up fans, ceiling mounted fans or fans attached to walls) during suspected or confirmed respiratory outbreaks. The policy shall include at a minimum the necessity of using supplemental ventilation units during outbreaks, what areas they will be used in, how they will be placed to direct air flow, for how long, how they will be monitored and managed to ensure that the transmission or spread of airborne or droplet infectious pathogens are

minimized and/or mitigated during their use.

4. Amend policy CM-VII-040, entitled "Standard Precautions" which requires that all items be labeled and stored in resident rooms, to include whether resident items (and the specific types of items) can be stored in communal areas such as tub rooms and the process for ensuring they are labelled and used with the identified resident only.

5. Re-develope the housekeeping policies and procedures in accordance with "Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, April 2018" and in consultation with the Haldimand Norfolk Health Unit.

6. Immediately report to the Haldimand Norfolk Health Unit, where two residents or staff members have the same respiratory related symptoms within a 48 hour period in accordance with the health unit requirements and prevailing practices identified as "Recommendations for the Control of Respiratory Infections in Long Term Care Homes, 2018".

7. Ensure outbreak control measures are initiated and maintained for all residents who are positive with Clostridium difficile, in accordance with the directives of the Haldimand Norfolk Health Unit and prevailing practices identified as "Testing, Surveillance and Management of Clostridium difficile in all Health Care Settings, January 2013".

8. Ensure that residents who are suspected of having clinical signs and symptoms of respiratory or enteric illness have the appropriate signage posted near or at the entrance of the room identifying the precautions that are to be taken when in the room of the affected resident(s) throughout the duration of their illness, and promptly removed when signs and symptoms cease for the required period of time.

Grounds / Motifs :

(A3)
1. 1. The licensee failed to ensure that the infection prevention and control program included measures to prevent the transmission of infections.

Several Complaints and Critical Incidents System (CIS) reports were reviewed during this inspection related to the infection prevention and control program.

According to Public Health Ontario and prevailing practices associated with outbreaks and measures to prevent the transmission of infections, the following practices have been identified ton reduce the number of infections, decrease the duration of outbreaks and/or mitigate negative outcomes associated with outbreaks and infections. These include but are not limited to increased cleaning and disinfection frequencies, appropriate and available personal protective equipment for staff and visitors, staff cohorting [limiting staff travel between home areas], appropriate and timely isolation procedures, hand hygiene, staff and resident immunizations, surveillance, timely reporting of potential cases and communication.

A) Complaints received included concerns regarding the lack of appropriate measures to prevent the transmission of infections.

During the inspection on three identified dates, no precautionary signage was posted upon entry to an identified number of residents' rooms regarding the type of precaution that was required. The signage would identify whether the visitor was required to wear protective gear and the type of precaution that was in place, whether contact, airborne or droplet.

According to the licensee's “Isolation Policy-ICM-IX-010" policy, transmission based precautions will be employed for all known or suspected infections for which the route is known, whether droplet, airborne or contact and staff were to obtain appropriate signage and post outside the door frame. No disinfectant supplies capable of killing the organism [product must state it can kill spores] were available in the washroom or in the room for personal support workers (PSW) to use to disinfect surfaces after they completed resident care. Registered Nurse (RN) #136 was concerned about resident safety risks associated with a disinfectant disposable wipe that was available in the home during inspection that was confirmed to be a sporicide. However, the product was not identified to be hazardous and was labeled as an irritant. If kept out of immediate reach of confused residents [i.e. stored in bathroom cabinet or on top of high wardrobe], the product was considered to be a low safety risk and the benefits of using it multiple times per day far outweighed the risks.

Concerns were identified related to nail care equipment not being disinfected adequately after use. During the inspection, both tub rooms included a storage organizer for resident supplies such as nail clippers and nail files. Each drawer was labeled with resident names; however, an identified number of residents did not have a nail clippers in the first floor tub room. One larger nail clipper was observed sitting on a surface in both tub rooms. On a subsequent date, Inspector #586 was informed by PSW #157 that one nail clipper that was larger was used on the same residents but disinfected after use. However, the PSW did not allow the disinfectant to have adequate contact time with the clipper before rinsing it. Neither the Director of Care (DOC) or the Administrator were able to find any instructions or policies related to how all staff were to clean and disinfect commonly used nail care equipment.

Other poor infection control practices were observed during the inspection which included:
i) Improperly stored urine measure hats on grab bars, toilet tank lids, the floor or on top of cabinets in resident rooms. Some were noted to be dusty or stained.

ii) Unlabelled deodorant products, hairbrushes and toothbrushes in communal storage cabinets in resident rooms and tub room on 1st floor. The licensee's policy named 'Standard Precautions (CMVII- 040)' required that all items stored in resident rooms be labeled to identify the resident. No details were provided regarding storage of resident supplies outside of their rooms.

iii) Staff carrying exposed dirty briefs down the corridors from resident rooms to inadequately sealed garbage receptacles.

iv) The use of portable fans in corridors and resident rooms during respiratory outbreaks. Fans were also noted to be heavily coated in dust.

B) According to outbreak incident reports filed with the Ministry of Health and Long-Term Care (MOHLTC), the licensee submitted six CIS reports identifying that their facility was experiencing either an enteric or respiratory outbreak over a six-week period. The reports included basic facts such as number of residents and staff affected, the duration of the outbreak, whether cultures were taken and the results and whether any deaths or hospitalizations occurred. During the inspection, records for five out of the six outbreaks were requested, as the sixth outbreak was ongoing. A detailed summary report or record for each outbreak completed by the infection

control designate was not available. A review of the meeting minutes for the Infection Prevention and Control Committee for 2018, did not include a review of the outcome of any outbreak or the statistics that were acquired to determine what future actions needed to be implemented to reduce the duration of outbreaks or minimize the number of residents or staff affected.

Records regarding the above noted outbreaks were acquired from the local public health unit and reviewed. According to public health outbreak summary reports for outbreaks in August 2017, December 2017, January 2018 and February 2018, which were sent to the licensee after each outbreak, failures were identified related to timely reporting, familiarity with the outbreak process (using appropriate line listing, faxing the data on a daily basis, one designated person as point of contact with the health unit), current staff immunization records, surveillance and tracking the population at risk within the home and enhanced disinfection requirements.

According to the licensee's 'Infection Control Surveillance-ICM-VII-010' and 'Respiratory Outbreak Protocol-ICM-VIII-020' polices, the DOC or designate was required to provide the health unit with an updated line listing on a daily basis, that the RNs would initiate a surveillance form, document in progress notes on every shift the presence or absence of symptoms and that the DOC or designate would gather further data for infection tracking and reporting. The policies were reflective of public health requirements for reporting, surveillance, data collection, the implementation of general infection control measures (staff cohorting, cleaning frequencies, personal protective equipment and signage, visitor precautions), communication and overall post outbreak assessment.

During the inspection, a respiratory outbreak was in effect and the DOC reported the outbreak to public health on an identified date. Surveillance forms were gathered from the registered staff. The names of and identified number of residents with different symptoms were listed. According to public health requirements, any two residents with the same two or more symptoms should have been reported to their local public health unit to alert them of a possible outbreak. The licensee did not initiate a report with public health until two days later after symptoms were present, at which time they had more residents with similar symptoms on both floors of the home. As of an identified date during the inspection, residents who were identified to be in isolation for their symptoms did not have any precautionary signage posted on the door or wall upon entry to the rooms or inside the rooms.

The DOC, when interviewed and was not aware that residents presented with different symptoms and had not collected the surveillance sheets from the two separate nurse's stations for review. When requested to provide their monthly statistics for the last 12 months, identifying which infections were prevalent, the duration of the infections and any other trends, none could be provided as they were not collected.

Interviews with housekeepers #167 and #168 and the housekeeping manager during the inspection revealed that additional hours were not always allocated during outbreaks to clean touch point surfaces in shared resident rooms and common areas. Challenges included finding staff to come into the home and financial resources. Housekeeper #167 reported that even on a day to day basis, the hours allocated to housekeepers was inadequate to provide proper and thorough cleaning. No housekeepers were present in the home beyond 1500 hours during the inspection while a respiratory outbreak was in effect. The frequency with which certain resident rooms and common areas such as dining rooms, lounges and corridors was not in accordance with outbreak control guidelines. The licensee's housekeeping policies and procedures, when reviewed, did not include current procedures and frequencies on cleaning and disinfecting the home in accordance with prevailing practices such as 'Best Practices for Environmental Cleaning for Prevention and Control of Infections in all Health Care Settings, April 2018'. The licensee's "Respiratory Outbreak Control Measures-ICM-VIII-021" policy, included enhanced cleaning practices in high traffic areas and the need to review cleaning protocols with the housekeeping staff through staff meetings.

The licensee therefore failed to ensure that the infection prevention and control program included measures to prevent the transmission of infections.

Please note this none compliance was identified during Compliant Inspection log #00889-18 and #016668-18 as well as during CIS Inspection log #021199-17, #029465-17, #009092-18, #03222-18 and #06346-18. [s. 86. (2) (b)] (120). (120)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 006

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically the licensee must:

1. Ensure that resident #004, resident #027, resident #038, resident #052 and any other residents are protected from abuse.

2. Develop a protocol/procedure for the observation and assessment of residents who demonstrate responsive behaviours that could potentially trigger altercations between residents.

3. Implement the above noted protocol/procedure for resident #006, resident #041 and any other resident who demonstrates responsive behaviours.

4. Ensure resident #006, resident #041 and any other resident's plans of care are updated in accordance with the above noted assessment, to include care interventions to reduce the risk.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that residents were not neglected by the licensee or staff.

In accordance with Ontario Regulation 79/10, s. 5, neglect means, "the failure to provide a resident with the treatment, care, services or assistance required for health, safety or well-being, and includes inaction or a pattern of inaction that

jeopardizes the health, safety or well-being of one or more residents".

A) The homes investigation package and the resident's plan of care was reviewed and interviews were completed with staff. On an identified date, resident #009 was found by personal support worker (PSW) #126 in a compromised situation. PSW #126 reported it to PSW #124, who was the primary care provider for resident #009. PSW #126 then went to their assignment and did not follow up to see that resident #009 had gotten the care they required.

When the Registered Practical Nurse (RPN) went to locate the resident they found resident #009 in the same identified area still in a compromised situation.

The Directror of Care (DOC), RN #125 and RPN #118, all confirmed when interviewed that this incident met the Ministry of Health and Long Term Care (MOHLTC) legislation in regards to neglect. The home failed to ensure that resident #009 was protected from neglect. (536)

B) The homes investigation package and the resident's plan of care was reviewed and interviews were completed with staff. When PSW #106 and #157 went to resident #001's to provide care the resident was found to be in a compromised situation and had not received the care they required. The resident was upset by the incident and there were slight changes in the residents condition when they were assessed.

According to the plan of care resident #001, the resident was required to be checked at a specific interval and to be assisted by a certain number of staff.

Interviews were completed with PSW #170 and #171 who were the assigned front line staff for resident #001 during the shift. It was confirmed resident #001 was not provided the care they required using the number of staff as directed in the plan care as the staff did not work together to provided the care to the resident on this shift. It was confirmed the resident was not checked at the required intervals but it was undetermined how long the resident was in a compromised situation before the required care was provided.

In an interview with the DOC it was confirmed that resident #001 did not receive the care they required. (583)

ii) In an interview with PSW #157 who regularly provided care to resident #001 it was shared that resident #001 had other incidents where their required care was not provided as directed in their plan of care. (583)

iii) Resident #001's documented plan of care indicated that they required specified care interventions related to their condition at a certain time of day.

On an identified date during the inspection, the resident as observed to require immediate care; however PSW #106 indicated that the home was short-staffed, and due to this, there was no staff available to provided the care at the time that was directed per their plan of care. The PSW stated this happened often when short-staffed. Resident #001 was not provided care as per their plan of care. (586)

iv) A review of resident #001's plan of care showed the resident had multiple falls over an identified period related to a particular behaviour. Resident #001 was assessed to be at a risk for falls and during their last quarterly assessment and it was documented the resident had a large number of falls over the quarter. Resident #001 was assessed for a specified level of assistance for care.

In an interview with the RAI-Coordinator it was identified that often the falls incidents were related to resident #001 trying to complete a certain task related to their behaviours when left unattended. It was confirmed that an individualized plan was not developed and implemented to manage resident #001 to effectively manage their care needs.

v) Resident #001 was not administered drugs in accordance with directions for use specified by the prescriber. This was acknowledged by RPN #129.

In summary the licensee failed to provide resident #001 with the care, treatments and assistance required for their safety and wellbeing. (583)

2. The licensee failed to protect residents from abuse by anyone.

A) Documentation from resident records by registered nursing staff were reviewed that described details of a resident to resident altercation between resident #041 and resident #052 that resulted in injury to resident #052. At the time of the inspection

resident #052 did not recall the incident. The licensee failed to protect resident #052 from abuse by resident #041.

B) Documentation from resident records by registered nursing staff were reviewed that described details of a resident to resident altercation between resident #038 and resident #006 that resulted in injury to resident #038 and resident #006. At the time of the inspection resident #038 recalled the incident. The licensee failed to protect the residents from abuse.

C) Documentation from resident records by registered nursing staff were reviewed that described details of a resident to resident altercation between resident #006 and resident #027 that resulted in injury to #027. The licensee failed to protect resident #027 from abuse by resident #006.

D) Documentation from resident records by registered nursing staff were reviewed that described details of a resident to resident altercation between resident #006 and resident #004 that resulted in injury to resident #004. At the time of the inspection resident #004 could not recall the incident. The licensee failed to protect resident #004 from abuse by resident #006.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it related to four of eight residents reviewed. The home had a level 3 compliance history of one or more related non-compliance in the last 36 months that included:

-Compliance Order (CO) issued February 23, 2016 (2015_188168_0031) – complied on February 23, 2017.
-CO and Directors Referral (DR) issued February 23, 2017 (2011_573581_0002)- complied on June 28, 2017

(129)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 007

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

Linked to Existing Order / Lien vers ordre existant: 2017_695156_0008, CO #001;

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee failed to comply with the following compliance order CO #001 from inspection #2017_695156_0008 served on February 26, 2018, with a compliance date of May 30, 2018.

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

The licensee shall prepare, submit and implement a written plan to ensure that all residents are bathed at a minimum of twice a week by a method of their choice. The plan must include, but is not limited, to the following.

1. A process of how the home will make up scheduled baths or showers when they are missed due to the home being short staffed, and where the action taken will be documented.

2. An auditing process to ensure residents are receiving minimum bathing requirements and how records will be maintained. Include the frequency in which the audits will be completed and who will be responsible for doing the audits and evaluation the results.

Please submit the written plan for achieving compliance by an identified date in January 2019.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents were bathed, at a minimum, twice a week by the method of their choice, including tub baths, showers and full body sponge baths and more frequently as determined by the resident's hygiene requirements, unless contraindicated by a medical condition.

In an interview with Personal Support Worker (PSW) #107, they indicated that it was the expectation of the home that staff were to document resident bathing on paper using the 'PSW Documentation Record' as well as electronically.

A review of the bathing records (including paper records and electronic) as well as interview with the Director of Care (DOC) confirmed that not all residents were bathed at a minimum of twice a week by a method of their choice.

A) Resident #011 voiced concern to the LTCH Inspector that they had missed their scheduled bath on an identified date in 2018, as well as multiple other baths during the year. Bathing record review and interview with PSW #107 confirmed that the resident missed their scheduled bath and did not receive this bath nor was it made up. The 'Daily 24 HR Report' also indicated that the resident's bath was missed. Review of past records also indicated that the resident missed their bath on additional dates.

B) A complaint was received from resident #010's family member that the resident was not receiving their two baths per week. Record review and interview with the DOC confirmed the resident did not receive their scheduled baths on an identified number of occasions and these baths were not made up. (506)

C) A review of the home's bathing records (including paper records and electronic) for an identified number of residents on dates over three months in 2018, where completed on selected dates where complainants identified shortages and lack of bathing. The residents reviewed missed their baths and these scheduled baths were not made up. Review of the staffing schedules confirmed that the home was short PSW staff on all of the dates identified.

D) According to the home's 'Daily 24 Hr Report' sheets, on an identified date in 2018, an identified number of residents on one of the floors did not receive their evening baths due to a staffing shortage. On another date, an identified number of residents did not receive their baths due to staffing shortage the report also indicated that the entire other floor was missed. The listed baths were not made up when the scheduled bath was missed as per bathing record documentation.

E) On two identified dates during the inspection, the home was short-staffed as confirmed by the home's management as well as staffing records. Review of the home's bathing records and interview with PSW #107 confirmed that baths were not completed for day or afternoon shifts on those dates. The residents scheduled for baths on those dates did not receive their baths, and the baths were not made up when the schedule baths were missed. [s. 33. (1)] (586)

The severity of the issue was determined to be a level 1 as there was minimum risk to the residents. The scope was a level 2, a pattern. The compliance history was a level 4 as the home has on going non-compliance with this section of the LTCHA that

included:

- Director's Review (DR) issued February 28, 2018 (2017_695156_0008)
- Compliance Order (CO) issued July 12, 2017 (2017_574586_0012)
- CO issued February 23, 2017 (2017_573581_0002). (586)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 008

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

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 complaint with O. Reg. 79/10, s. 31 (3) of the LTCHA.

The licensee shall prepare, submit and implement a written plan to ensure that there is a written staffing plan. The plan must include, but is not limited, to the following.

1. A description of a staffing plan that will be implemented for first and second floor that will provide a staffing mix that will meet residents' assessed care and safety needs.

2. A description of an auditing process that will be used to evaluate if resident care needs are being met on a daily basis.

i) Include how staff shortages will be tracked.
ii) Include how the home will identify, track and document any resident care or safety needs that are identified when there are staff shortages.
iii) Include a plan on what action will be taken to meet care and safety needs in these circumstances.
iv) Identify who will evaluate the audits and what frequency they will be completed.

3. A description of a backup plan that will be put in place when Personal Support Workers and Registered Practical Nurses cannot come to work. Include who will be responsible for implementing the plan.

4. A description of what strategies the licensee will use to promote continuity of care for residents.

5. A description of what strategies the licensee will use to maximize the recruitment and retention of staff.

Identify how all of the above information will be documented and recorded.

Please submit the written plan for achieving compliance by and identified date in January 2019.
Please ensure that the submitted written plan does not contain any PI/PHI.

Grounds / Motifs :

1. 1. The licensee has failed to ensure that the home's staffing plan provided for a staffing mix that was consistent with residents' assessed care and safety needs, set out the organization and scheduling of staff shifts, promoted continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident, included a back-up plan for nursing and personal care staffing that addressed 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 be evaluated and updated at least annually in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices.

From July 2017 to September 2018, the Ministry of Health and Long Term Care (MOHLTC) received 31 complaints and one Critical Incident System (CIS) report related to a staffing mix that was no consistent to meet residents' assessed care and safety needs.

Complainants shared that there were incidents where the following residents' care needs were not provided when the home was short staffed:
- Continence care
- Bathing
- Oral care
- Foot and nail care
- Dressed appropriately for time of day and in clean clothing
- Hygiene and grooming
- Preferred bedtime and rest routines
- Assistance with meals
- Snack service in the afternoon and evening
- Safe transferring and positioning techniques
- Assistance from two staff when required
- Falls prevention including monitoring of residents
- Responsive behaviours including monitoring of residents and implementing interventions

2. Cedarwood Village is a Long-Term Care Home (LTCH) with a licensed capacity of 91 beds, with 46 residents on the first floor and 45 residents on the second floor. The licensee used a "Daily Assignment Sheet" which had the following staff mix over a 24 hour (hr) period for Registered Nurses (RN), Registered Practical Nurses (RPN) and

Personal Support Workers (PSW):
RN's - three staff per day, scheduled from 0600 to 1400 (hours) hrs, 1400 to 2200 hours and 2200 to 0600 hrs.

RPN's - First floor, two staff per day, scheduled from 0600 to 1400 hrs and 1400 to 2200 hrs.

- Second floor, two staff per day, scheduled from 0600 to 1800 hrs and 1800 to 0600 hrs. (except Fridays where three 8hr shifts of RPNs were scheduled)

PSW's - First and second floor each had 12 staff per day, five staff scheduled from 0600 to 1400 hrs, five staff from 1400 to 2200 hours and two staff from 2200 to 0600 hrs.

In interviews with the Administrator and Director of Care (DOC) it was confirmed that this staffing mix was used in 2018, and it was the staffing mix in place at the time of the inspection that was required to meet the residents' assessed care and safety needs.

A) The planned staffing mix for RN's in the home, for the direct care of residents, was three Registered Nurses (RN) for a total of 24 hours per day, as identified on work schedules provided by the home and confirmation by the DOC in September 2018.

During an interview with the Ward Clerk and DOC, they identified that the home did not have a sufficient number of RNs within the staffing plan to fill all shifts related to staffing events such as sick calls and vacation coverage. The DOC confirmed that the home consistently offered additional shifts to regular RNs to fill these vacant shifts; however, when the RNs employed by the home were unwilling or unable to work one or more of the required shifts, the home would fill those shifts with RPNs in combination with the DOC being on call and use an agency RN.

There were several complaints that were received by the Director in which it was identified that there were RN shortages taking place in the home. After a review of the schedules it was identified that there was no RN in the building on five shifts in July 2018, on three shifts in August 2018 and on four shifts in September 2018. In addition there were three shifts in July and one in August 2018 where an agency RN was used. The DOC confirmed that the need to fill these RN shifts were not the result

of emergency situations as outlined in O. Reg 79/10, s. 45(2).

Interviews were conducted with two RN's to identify if there were areas of their work routines that they were unable to complete when the homes staffing mix was not met. It was shared that staff shortages sometimes impacted resident care, specifically:
- Falls monitoring and prevention strategies aren't implemented;
- Feeding assistance;
- Weekly skin and wound assessment;
- Completion of reports and assessments when the RN has to work assisting with RPN or PSW duties during shortages; and,
- Team meetings

In an interview with the DOC it was confirmed that the home did not have any RN job routines in place to direct staff as to what care and duties they were responsible for on the various shifts.

B) The planned staffing mix for RPNs in the home for direct care of residents, was two RPNs working on each floor (totaling four) on Saturday through Thursday, and on Fridays each week, there should be three RPNs working on the second floor and two RPNs on the first floor (totaling five).

A review was conducted of the staffing levels on select dates in July and August, 2018, as many complainants identified that staff shortages often occurred in the summer months particularly over weekends. Select dates in September 2018 were also reviewed as a result of the complaints brought forward.

It was identified through staffing records that there were 19 dates between July and September 2018 where the home was short RPN shifts.

Interviews were conducted with three RPN's to identify if there were areas of their work routine that they were unable to complete when the homes staffing mix was not met. It was shared that staff shortages sometimes impacted resident care, specifically:
- Medication administration occurring late, resulting in time-sensitive medication being delayed, as well as upset residents;
- Pain assessments unable to be completed;

- Slow call bell response times, caused residents to wait extended periods of time for staff to respond;
- Reduction in time spent monitoring residents with responsive behaviours and palliative residents; and,
- Registered staff going without any breaks, even during a 12-hour shift, resulting in increased risk for error in care provided.

In an interview with the DOC it was confirmed that the home did not have any RPN job routines in place to direct staff as to what care and duties they were responsible for on the various shifts.

C) The planned staffing mix for PSW's in the home for direct care of residents, was five PSWs working on each floor of the home on day and evening shifts (totaling 10), and two PSWs working on each floor on the night shift (totaling four).

A review was conducted of the staffing levels on select dates in July and August, 2018, as many complainants identified that staff shortages often occurred in the summer months particularly over weekends. Select dates in September 2018 were also reviewed as a result of the complaints brought forward.

It was identified through staffing records that there were 25 dates between July and September 2018 where the home was short PSW shifts.

Interviews were conducted with six PSW's they confirmed PSW staff were often not able to meet all of the residents care needs as per the residents plan of care when the home had significant PSW shortages.

i) Specifically, the LTCH Inspectors received multiple complaints about the staffing levels on the Labour Day long weekend (August 31 to September 2, 2018). As indicated above, there should be ten PSWs working in the home on day and afternoon shifts. According to the Time Card Summary Report sheets for September 1, 2018, which reflected staffing punch card logs, only four PSWs worked on the day shift on September 1, 2018, to care for all 91 residents, and only five on the afternoon shift.

ii) In an interview with PSW #119 during the RQI, they indicated that call-ins were not the only reason for the staffing shortages, but also due to under-staffing prior to the

shifts. A review of the daily assignment sheet for September 22, 2018, revealed that only two PSWs were scheduled to work the evening shift on the second floor, prior to the shifts and any call-ins.

iii) The home had a Professional Advisory Committee (PAC) and a meeting was held in April 2018, and the following staff were in attendance: the DOC, Physician, RD, RAI Coordinator, amongst others. The meeting minutes were reviewed. It was documented, staffing concerns limit the ability of members of the health care team to obtain information they require, related to missing documentation.

3) While inspecting the following resident care needs, actual and potential impacts to the care of residents were identified:

A) A review of the home's bathing records for three months in 2018 was completed. It revealed that certain residents missed their baths on fifteen dates in that time period and these baths were not made up. Review of the staffing schedules confirmed that the home was short PSW staff on all listed dates.

B) On an identified during the inspection in the late afternoon, seven residents were observed by the LTCH Inspector to be wearing their night time attire. An interview with PSW #134 and #135, confirmed that the above residents' plans of care did not include being placed in their night time attire prior to the dinner meal as the residents' preferences. The PSW's also confirmed that the residents were placed in their night time attire at this time because they were short PSW's to help with care later in the evening.

C) Resident #001's documented plan of care indicated that they were incontinent and required specified assistance with continence care at specified intervals.

On an identified date during the inspection, the resident as observed to require continent care; however PSW #106 indicated that the home was short-staffed, and due to this, there was no staff available to provide the specified care. Resident #001 was not provided care as per their continence plan of care.

D) On an identified date in 2017, the home was short-staffed on the day shift as confirmed by the home's investigation notes, management, as well as staffing records. A review was completed of the home's investigation notes, which stated

that due to staff shortage on the identified date, a number of residents had not received the care they required and were left in a compromised situation for the oncoming shift.

During interviews with two PSWs who both worked that day, staff stated they were unable to provide the required care to all the residents because they were short staff. During interview with the DOC they confirmed that they determined that staff shortage was the reason for not completing all their assigned resident care.

E) A meal service observation was completed on an identified date during the inspection. PSW #119 was alone in the dining room with 12 residents. The PSW was observed assisting residents #003, #004 and #006 with eating. The PSW indicated that all three residents needed to be fed their meals and beverages that day. They also indicated that there were three other residents in the dining room that required intermittent assistance. The PSW was observed going between two tables assisting residents #003, #004 and #006 as well as the other resident who required intermittent feeding assistance. Resident #002's food sat in front of them for 45 minutes and the PSW indicated that they had not had time to assist the resident yet.

Resident #003's documented plan of care indicated that they required assistance with eating. In an interview with the RD, they confirmed that resident #004 required assistance with eating. It was confirmed the resident was not provided the feeding assistance they required. It was noted the home was short eight PSWs in a 24 hr period on the identified date. (586)

F) On an identified date during the inspection, meal service was observed.

i) Review of the health records of residents #003, #004 and #005 did not include any documentation of the food or fluid intake for the meal. In an interview with PSW #107, PSW #119 and RPN #120, it was shared the expectation of the home that documentation was to be completed prior to the end of every shift; however, indicated that when the home was short-staffed, documentation would at times not get completed.

ii) PSW #119 was alone in the dining room with 13 residents. The PSW was observed assisting residents #002, #003, #004 and #005 with eating. The PSW

indicated that all four residents needed to be fed their meals and beverages that day. The PSW was observed going between two tables giving each residents a few bites of their food before moving onto the next resident, in addition to clearing other residents' plates and serving them their dessert. The PSW was standing beside the residents while feeding them rather than sitting. The PSW indicated that they were aware they were not supposed to be assisting multiple residents; however, due to the lack of staffing, they were required to assist all four residents simultaneously.

Resident #003's documented plan of care indicated that they required assistance with eating. In an interview with the RD, they confirmed that resident #004 required assistance and it was confirmed the resident did not get the assistance they required with feeding. (586)

iii) A meal service was observed on an identified date during the inspection on the second floor. PSW #119 was alone in the dining room with 13 residents. The PSW was observed assisting residents #003, #005, #002 and #004 with eating. The PSW was observed going between two tables giving each residents a few bites of their food before moving onto the next resident, in addition to clearing other residents' plates and serving the remainder of the dining room their dessert. The PSW was observed encouraging resident #003 to have some of their fluids; however, this was not done for the other residents. When all residents were finished their meals, resident #003 had one 250 ml glass of fluid and one 250ml glass of another fluid remaining that they had not consumed. Resident #004 had two 250 ml glasses remaining that they had not consumed, though the resident had attempted to drink these themselves throughout the meal without success. Resident #005 had two 250 ml glasses of fluid remaining that they had not consumed, though the resident had attempted to drink these themselves throughout the meal without success.

Resident #003's, #004's and #005's documented plan of care indicated they were at nutritional risk and that they required assistance with feeding.

PSW #119 confirmed that resident #003, #004 and #005 did not get the personal assistance and encouragement required and were not provided there required amounts of fluids. They were the only front line staff present during the meal service and shared they were short staffed. (586)

Please note that this area of non-compliance was identified during Complaint

inspections.
Interview with three registered nursing staff and one PSW as well as review of the staffing schedule for the identified date, it was confirmed the home was seven PSWs short in a 24 hr period on the identified date.

G) During an observation on a specified date during the inspection, two residents were observed sitting in an identified area and no staff were present.

Resident #004 had a full container of puree snack with a spoon in it and a full beverage with a lid on it and it was observed to be on the floor in front of the resident. Resident #004 was at nutrition risk and required assistance and supervision while eating due to risk related to their medical diagnosis.

Resident #002 had a puree snack and beverage. No beverage was taken and the snack was spilled and on its side with a spoon in it. The Inspector asked if the resident could take a spoon of the snack and they were unable to feed themselves at the time of the observation. Resident #002 was at nutrition risk and was assessed to require monitoring when eating due to risk related to their medical diagnosis. The plan of care directed staff to provide cueing and feeding assistance with eating.

It was confirmed with the Administrator, that only two out of five scheduled PSW's were working on the floor at the time of the observation. It was confirmed that resident #002 and #004 were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. (583)

Interview with RPN #118, RN #117, RPN #120 and PSW #119 as well as review of the staffing schedule for the identified date, confirmed that there were only three PSWs working on the first floor and one regular PSW and one agency PSW working on the second floor. It was noted the home was seven PSWs short in a 24 hr period on the identified date.

G) On an identified date a tour was complete of an identified floor and it was noted that a number of snacks and beverages were unfinished at resident bedsides in the home. Residents were present in some of the rooms.

An interview was completed with DA #139 it was shared the snack cart came back to

the kitchen from the second floor and beverages and regular snacks were distributed but some modified texture and special snacks were returned on the cart.

In an interview with two PSWs it was shared the snacks and beverages were handed out but the staff were unable to provide feeding assistance to residents that required assistance with eating due to short staffing. It was confirmed with the Administrator that only two out of five scheduled PSW's were working on the identified floor. It was confirmed that residents on that floor who required feeding assistance were not offered assistance and therefore were not offered a beverage or snack.

4. Issues were raised by the Resident and Family Councils in regard to the staffing levels in the home.

Review of the Residents' Council meeting minutes identified the following concerns were identified to the home:
- Wait times for personal care, wait times for assessment by Registered Dietitian (RD);
- PSW staffing shortages, recommendations for programs;
- Missed baths, missing items, dietary;
- Continence care, PSW shortages, staff approach, housekeeping, lack of programs; and,
- The management of responsive behaviours, maintenance, personal care not being provided, and missing items.

The home was also aware of Family Council concerns as they received a letter, outlining their concerns in the home, mainly regarding the staffing levels and subsequent effects on resident care.

5. Inspector #586 requested to see the licensee's written staffing plan for the organized program of nursing and personal support to identify if the requirements in O. Reg. 79/10, s.31(3) were included.

A document was provided by the DOC titled, "Staffing Plan: Personal Support Workers" dated September 2018. The document indicated that it was put into place to ensure baths were being completed despite staffing shortages, and it was noted the home had a previous Compliance Order (CO) related to residents not being bathed two times per week. Except for bathing, there was no further information. It

was confirmed that there was no further information detailing a staffing plan that could be located.

The Administrator and DOC confirmed that there was no staffing plan in place at the time of the inspection.
- It was unable to be confirmed if the staffing mix currently being used in the home was consistent with residents' assessed care and safety needs.
- There was no written plan that set out the organization and scheduling of staff shifts.
- There was no written plan that identified how the home promoted continuity of care or how the home minimized the number of different staff members who provided nursing and personal support services to residents. During the course of the inspection it was noted that staff would have to work on different units than they regularly worked, staff who mainly worked in other departments (food service, housekeeping) would work as a PSWs and agency staff were used due to short staffing.
Records provided by the Administrator identified agency PSW staff were used on 58 dates between July and September, 2018.
- There was no written back up plan for nursing and personal care staff to address situations when staff could not come to work.
- There was no written updates or evaluations of the staffing plan. In an interview with the Administrator in October 2018, they confirmed that the last annual evaluation of the home's staffing plan located was from 2015, and indicated that there were no other annual evaluations found since that time.

In summary, over the course of the inspection, the licensee did not meet the staffing mix set out by the home, did not meet the assessed care and safety needs of the residents and did not ensure a staffing plan was in place in the home. [s. 31. (3)] (536)

The severity of the issue was determined to be a level 2 as there was potential for actual harm to residents. The scope of the issue was a level 2 pattern based on the number of times staff shortages were identified. The home had a level 3 compliance history of one or more related non-compliance with this section of Act in the last 36 months, which included:

- Compliance Order – February 23, 2017, RQI (2017_573581_0002), complied June

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

28, 2017.

(536)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2019

Order # / Ordre no : 009

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 77. Food service workers, minimums

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 77

Specifically the licensee must:

1. Ensure that there are sufficient food service workers for the home to meet the minimum staffing hours as calculated at 354.9 hours per week.

Grounds / Motifs :

1. 1. The licensee failed to ensure that there were sufficient food service workers for the home to meet the minimum staffing hours as calculated under subsection (2).

The minimum number of hours per week were calculated as follows:

$M = [A \times 7 \times 0.45] + [(B \div 3) \times 0.45]$

Where,

"M" is the minimum number of hours per week for the activities outlined under subsection 77 (1) of the Regulation and the same or other activities related to meals for persons who are not residents defined under B;

"A" is the occupancy of the home is 97 per cent or more, the licensed bed capacity of the home for the week; and,

"B" is the total number of meals prepared in the home for the week for persons who are not residents of the home where one or both of the following two conditions are met:

(i) staff are involved in activities in addition to food preparation including but not limited to the following:
(a) distribution of meals;
(b) receiving, storing and managing of the inventory of food and food service supplies;
(c) daily cleaning and sanitizing of dishes, utensils and equipment used for meal preparation, delivery or service.

(ii) the menus for residents and persons who are not residents are not the same.

A review of the home's dietary job routines identified that the cook and dietary aides participated in food production, distribution of meals, inventory and cleaning for the retirement home in addition to the long-term care home. This was confirmed by cook #142 and the Nutrition Manager.

A review of food service worker regular scheduled hours through job routines and four-week schedules identified six food service staff and one cook were scheduled daily for a total of 333 hours per week. The Nutrition Manager confirmed the food service worker hours for the four week period reviewed and also identified that this was the regular scheduled hours that were in place in 2018.

The home's minimum required hours per week, with the home above 97 per cent capacity, was calculated as 354.9 hours.

The Administrator and Nutrition Manager acknowledged that the minimum food service worker hours were not being met by 21.9 hours per week. [s. 77.]

The severity of the issue was determined to be a level 1 as there was minimal risk to the residents. The scope was a level 3 widespread as the home was consistently short each week in the staffing minimum. The compliance history was a level 3 as there was related ongoing non-compliance that included:

- Voluntary Plan of Correction (VPC) – February 23, 2017, RQI (2017_573581_0002).
(586)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
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Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 010

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

Pursuant to / Aux termes de :

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

Order / Ordre :

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

Specifically, the licensee must:

1. Review the home's access to Registered Nurses (RNs) that are an employee of the licensee and members of the regular nursing staff of the home to ensure there are enough RNs to meet the licensee's staffing needs and allow for absences such as illness and vacation coverage and implement recruitment strategies.

2. Retain records of when scheduled RNs are unable to work and what action is taken.

3. Ensure that a RN who is an employee of the home is scheduled to work in the home and on duty and present at all times except as provided for in the regulations.

Grounds / Motifs :

1. 1. The licensee failed to ensure that there was at least one Registered Nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Cedarwood Village is a long term care home with a licensed capacity of 91 beds. The

planned staffing pattern for registered nursing staff in the home, for the direct care of residents, was three RNs for a total of 24 hours a day, as identified on work schedules provided by the home and confirmed by the DOC on September 19, 2018.

During an interview on September 20, 2018, with the Ward Clerk and DOC they identified that the home did not have a sufficient number of RNs within the staffing plan to fill all the shifts related to staffing events such as sick calls and vacation coverage. The DOC confirmed that the home consistently offered additional shifts to regular RNs to fill these vacant shifts; however, when the RNs employed by the home were unwilling or unable to work one or more of the required shifts the home would fill those shifts with RPNs in combination with the DOC being on call and use an agency RN.

The RNs shift times over a 24 hour period were as follows:
Days 0600 to 1400 hrs
Evenings 1400 to 2200 hrs
Nights 2200 to 0600 hrs

There were several complaints that were received at the Ministry of Health in which it was identified that there were RN shortages taking place in the home. On request the home provided RN schedules from May 20 until October 12, 2018.

After a review of the schedules it was identified that there were RN shortages at the home and these dates and times were confirmed with the DOC on October 15, 2018.

- On July 20, 2018, there was no RN in the building from 0800 - 0900 hours,
- On July 21, 2018, there was no RN in the building from 1800 - 0600 hours,
- On July 23, 2018, there was no RN in the building from 1400 - 2200 hours,
- On July 24, 2018, there was no RN in the building from 1700 - 2200 hours,
- On July 25, 2018, there was no RN in the building from 1730 - 2200 hours,
- On July 25, 2018, the home used an agency RN for the night shift,
- On July 26, 2018, the home used an agency RN from 1700 - 2200 hours,
- On July 27, 2018, the home used an agency RN from 1700 - 2200 hours,
- On August 11, 2018, the home used an agency RN from 1715 - 2200 hours,
- On August 12, 2018, there was no RN in the building from 1530 - 2200 hours,
- On August 13, 2018, there was no RN in the building from 0730 - 0900 hours,
- On August 23, 2018, there was no RN in the building from 0215 - 0600 hours,

- On September 18, 2018, there was no RN in the building from 1700- 2200 hours,
- On September 19, 2018, there was no RN in the building from 1700- 2200 hours,
- On September 20, 2018, there was no RN in the building from 1700- 2200 hours,
- On September 27, 2018, there was no RN in the building from 2200- 0600 hours.

The DOC confirmed that the need to fill these RN shifts were not the result of emergency situations as outlined in O. Reg 79/10, s. 45(2).
The home did not ensure that there was at least one registered nurse who was an employee of the licensee and was a member of the regular nursing staff on duty and present at all times.

Please note this area of non-compliance was identified during Complaint Inspection log #004149-18, #004854-18, #004149-18 and #003007-18. [s. 8. (3)]

The severity of this issue was determined to be a level 2 as there was a potential for harm to the residents. The scope of the issue was a level 2, pattern. The home had a level 4 history as they had on-going non-compliance with this section of the LTCHA that included:

- compliance order (CO) #007 issued February 23, 2017, with a compliance date of July 31, (2017_573581_0002)
-compliance order (CO) #001 issued July 12, 2017, with a compliance date of February 18, 2018 (2017_574586_0012)
-compliance order (CO) #003 issued February 26, 2018 complied on May 1, 2018 (2017_695156_0008) (506)

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

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 011

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 11. (2) Without restricting the generality of subsection (1), every licensee shall ensure that residents are provided with food and fluids that are safe, adequate in quantity, nutritious and varied. 2007, c. 8, s. 11. (2).

Order / Ordre :

The licensee must be compliant with s. 11 (2) of the LTCHA.

Specifically the licensee must:

1. Ensure all food and fluids provided to residents are safe.

2. Develop and implement a policy and procedure for thickening and providing thickened fluids to residents in the home in consultation with the Registered Dietitian.

3. Train food service staff and direct care staff on the home's policy, as well as on any specific procedures related to their duties.

4. Document and maintain attendance records.

5. Maintain records of the training material content used to train staff in the identified areas.

6. Develop a system to monitor that the thickened fluids are being prepared per the homes procedures and that residents on thickened fluids are provided a fluid consistency that is safe and based on their assessed needs.

Grounds / Motifs :

1. 1. The licensee failed to ensure that residents were provided with food and fluids

that were safe.

A) i) A meal observation was completed in an identified dining room during the inspection. Two large containers of unlabeled bulk thickening powder were observed in the dining room. One container contained a small metal soup spoon and the other contained a measuring spoon labelled "5cc". Inspector #583 asked spoke with the PSW staff in the dining room and it was confirmed that there were no mixing instructions or measuring spoons available in the dining room for front line staff. The mixing instructions required teaspoon (tsp) and tablespoon (tbsp) measurement tools to prepare correctly.

Two residents were observed who were assessed to be at nutrition risk that required their fluids to be thickened to a specified consistency. Staff prepared the thickened fluids for each resident in the dining room at their tableside. Both staff prepared the thickened fluids without referring to a recipe and without using measuring spoons. Both residents were observed to receive less thickening product than what was required to thicken their fluids per the mixing guide.

ii) An additional lunch observation was completed on the same day in another dining room in the home. One large container of unlabeled bulk thickening powder was observed in the dining room. The container contained a 30 ml measuring cup. It was confirmed that there were no mixing instructions or measuring spoons available in the dining room for front line staff.

One resident was observed who was assessed at nutrition risk that required their fluids to be thickened to a specified consistency. When asked by Inspector #583 what fluid consistency the resident required they shared they didn't know and it was confirmed that staff prepared the residents thickened fluids using less thickener than required.

iii) During meal observations made on the same day containers of crushed crackers were observed to be in a bulk container. In an interview with PSW staff in the dining room they shared that they were used to thicken soup but did not have a recipe to follow. In an interview with the RD it was shared soups should be thickened using the thickener product, as the crackers do not make a smooth consistent texture. It was confirmed that there was not a process for thickening soups in the home at the time of the interview and approximately eight residents in the home required there

soups to be thickened.

An interview was completed was completed with the Administrator, DOC and Food Service Manager. At the time of these observations the home was not using any pre-thickened products. It was confirmed that there were no mixing instructions or measuring spoons in any of the five dining rooms and that the front line staff did not have the information they required to prepare thickened fluids to a safe consistency that the residents assessed to need thickened fluids required. Three residents were provided thickened fluids that were not as thick in consistency as they were assessed to require.

B) A meal observation was completed in a dining room in the home on an identified date after the above observations were made and after management in the home confirmed that front line staff did not have the information they required to prepare thickened fluids to a safe consistency.

One resident was observed who was assessed at nutrition risk that required their fluids to be thickened to a specified consistency. PSW #159 confirmed there were no mixing instructions or measuring spoons available in this dining room for staff to refer to for direction and no direction had been provided by the home. It was confirmed that staff prepared the residents thickened fluids using less thickener than required and that the fluid consistency provided to the resident was not safe.

The severity of this issue was determined to be a level 2 as there was risk for harm to the residents. The scope was identified to be a 3 widespread as the home did not have a process in place to thicken fluids for any residents in the home. The home had a level 3 compliance history as there were ongoing related non-compliance with this section of the LTCHA that included:

- Voluntary Plan of Correction (VPC) for r. 68(2)(b) issued on May 31, 2017 (2017_574586_0012)
- Compliance Order (CO) for s. 6(5) issued on February 17, 2017 (2017_57381_0002)
- VPC for r. 8(1) (b) issued on February 17, 2017 (2017_57381_0002)
- CO for 6(10) (b) issued on February 23, 2016 (2015_188168_0031)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

(583)

This order must be complied with by /
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Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 012

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

Pursuant to / Aux termes de :

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

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

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

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

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

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

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

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

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

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

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

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 50 (2) (b) (iv) of the LTCHA.

Specifically the licensee must:

1. Ensure that resident #024, resident #045, resident #044 and any other residents who demonstrates altered skin integrity are reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

2. Develop and implement a mechanism to audit the completion of weekly skin assessments and maintain records of the outcome of the audits completed.

Grounds / Motifs :

1. The licensee failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, was reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

Interview with RN #136 verified the expectation of the licensee which was that areas of altered skin integrity were to be assessed and documented weekly on the resident wound assessment form.

A) Resident #024 was identified to have an area of altered skin integrity on a specified date. A review of the clinical record did not include a reassessment of the resident's area of altered skin integrity on a weekly basis. Interview with RN #136, identified when the home changed their electronic documentation system in April 2018, they thought the program allowed for weekly wound assessments. The RN confirmed that it was sometime in the summer that they realized that the weekly wound assessments were not being completed. At the time of this inspection the home could only produce four weekly wound assessments that were completed from April until September 2018.

B) Resident #045 was identified with two areas of altered skin integrity. A review of the clinical record for resident #045 were completed. It was identified in one month there were 21 days between completed assessments and in following month, there were 14 days between assessments. Interview with RN #136, confirmed that the weekly wound assessments were not completed.

C) Resident #044 was identified with an area of altered skin integrity. In an interview with RN #136, confirmed that there had been no further weekly wound assessments completed at the time of this inspection after the alteration in skin integrity had been initially identified. [s. 50. (2) (b) (iv)]

The severity of this issue was determined to be a level 2 as there was minimal harm or potential for actual harm to the residents. The scope of the issues was identified as level 3 as it related to three of three residents reviewed. The home had a level 3 compliance history of one or more related non-compliance with this section of Act in the last 36 months, which included:

- Voluntary Plan of Correction (VPC) issued for r. 50(2)(a)(ii) issued February 23, 2016, (2015_188168_0031)
- VPC issued for r. 50(2)(b)(i) issued February 23, 2016, (2015_188168_0031)
- VPC issued for r. 50(2)(b)(iv) issued February 23, 2016, (2015_188168_0031)
- VPC issued for r. 50(2)(b)(iv) issued February 23, 2017 (2017_573581-0002
- VPC issued for r. 50(2(b)(i) issued July 12, 2017, (2017_574586_0012)
- VPC issued for r. 50(2(b)(iii) issued July 12, 2017, (2017_574586_0012)
- VPC issued for r. 50(2(b)(iv) issued July 12, 2017, (2017_574586_0012)
- VPC issued for r. 30(1)) issued July 12, 2017, (2017_574586_0012)
- VPC issued for s. 76(7) 6 issued July 12, 2017, (2017_574586_0012)

(506)

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Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 013

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10 s. 131 (2) of the LTCHA.

Specifically the licensee must:

1. Ensure drugs are administered to resident #001, resident #004, resident #006, resident #054 and any other resident, in accordance with the directions for use specified by the prescriber.

2. Develop and implement a policy/procedure to monitor the application of transdermal patch medications to ensure residents who physicians have ordered medications to be administered via this route, receive the medications as prescribed by the physician. Provide training to the registered nursing staff and obtain records.

3. Develop and implement a system to audit the above mentioned monitoring system and maintain records of those outcome of those audits.

4. Develop and implement a policy/procedure to ensure registered staff are made aware of resident's bowel patterns to ensure that when resident's physicians have ordered drugs to be administered to residents related to their bowel protocol that those drugs are administered in accordance with the directions from their physicians. Provide training to the registered nursing staff and obtain records.

5. Develop a system to audit residents whose physicians have ordered them to receive drugs base on the resident's bowel protocol and maintain records of the outcome of the audits.

Grounds / Motifs :

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

A) A Critical Incident System (CIS) report was submitted to the Director, regarding a missing controlled substance. Clinical record review confirmed that an identified resident had a physician's order for a medication patch and the order was to remove one patch and then apply one patch topically at an identified frequency. On an identified date, RPN #113 went to remove the patch and the patch was removed

from the transparent dressing that had been applied to the resident. In an interview with the DOC it was confirmed that the resident did not receive the required dose of the medication patch as the patch was not administered to the resident in accordance with the directions for use specified by the physician. (506)

Please note this non-compliance was identified during CIS Inspection log #004588-18-18.

B) The home submitted a CIS report #2768-000022-18, related to the management of resident #001's care.

When reviewing the residents plan of care it was identified that the resident had specified continence care interventions to reduce their risk of falls. An intervention included a bowel routine ordered by the physician to manage constipation.

The clinical health records were reviewed for resident #001, #004, #054 over a 30 day period. Documentation of the resident's bowel movements and medication administration records were reviewed. The resident's eMar included a physician's orders for specified doses a stool softener and laxative to be provided at specified intervals based on the resident's bowel movements.

i) According to the resident #001 clinical health record:
They did not receive their prescribed stool softener on three required occasions.
They did not receive their prescribed laxative on two required occasions.

Resident #001 was not administered drugs in accordance with directions for use specified by the prescriber. This was acknowledged by RPN #129. (583)

Please note this non-compliance was identified during CIS Inspection log # 028474-18.

ii) According to resident #004's clinical health record:
They did not receive their prescribed stool softener on three required occasions.
They did not receive their prescribed laxative on three required occasions.

Resident #004 was not administered drugs in accordance with directions for use specified by the prescriber. This was acknowledged by staff #129. (586)

iii) According to the resident #054's clinical health record:
They did not receive their stool softener on two required occasions.
They did not receive their laxative on one required occasion.

Resident #054 was not administered drugs in accordance with directions for use specified by the prescriber. This was acknowledged by staff #129. (586) [s. 131. (2)]

The severity of this issue was determined to be a level 2 as there was the potential for actual harm to the residents. The scope of the issue was a level 2 as it related to four of six residents reviewed. The home had a level 3 compliance history of one or more related non-compliance in the last 36 months with this section of Ontario Regulation 79/10 that included:

-Voluntary Plan of Correction (VPC) issued July 12, 2017, (2017_574586_0012)

(506)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 01, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 014

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

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Order / Ordre :

The licensee must be compliant with s. 76 of the LTCHA.

Specifically the licensee must:

1. Ensure all staff in the home are trained annually on the home's policy to promote zero tolerance of abuse and neglect of residents and the duty under section 24 to make madatory reports.
ii) Ensure training is done using the homes current policies.
iii) Ensure the written policy to promote zero tolerance of abuse and neglect includes the required contents identified in s. 20 (2) of the LTCHA.

2. Ensure all direct care staff are trained trained in the following area annually.
i) Abuse recognition and prevention.
ii) Mental health issues, including caring for persons with dementia.
iii) Behaviour management.
iv) Skin and wound management.
v) Falls prevention and management.
vi) Continence care and bowel care.

3. Document and maintain attendance records.

4. Maintain records of the training material content used to train staff in the identified areas.

5. Assign a designated lead for the training and orientation program.

Grounds / Motifs :

1. 1. The licensee failed to ensure that no person mentioned in subsection (1) performed their responsibilities before receiving training in the areas provided for in the regulation.

A concern was voiced to Inspector #506 when they were speaking with a complainant that the home was using a Personal Support Worker (PSW) to work as a Registered Nurse (RN). A review of the schedules confirmed that the staff member was listed on both the PSW and RN schedules. An interview with the Director of Care (DOC) confirmed that a PSW who worked at the home recently had become registered with the College of Nurses as an RN. It was noted that the staff member worked two evening shifts as the RN in charge of the building on two identified dates. An interview with the staff member, confirmed that they had not received any formal training or orientation at the home before completing their scheduled shifts as an RN in charge of the building. An interview with the DOC, confirmed they were on call when the staff member was working the above shifts and they had received some informal training prior to the shift. The DOC confirmed that the staff member should not have worked without having the required training but felt that it was better than not having an RN in the building. [s. 76. (2) 11.]

2. The licensee failed to ensure that all staff in the home received training under s. 76, subsection 2(3), the long-term care home's policy to promote zero tolerance of abuse and neglect of residents and (2) 4, the duty under section 24 to make mandatory reports received retraining at times and intervals provided for in the regulations. In accordance with O. Reg. 79/10, s. 219. (1), the licensee was required to retrain all staff in the home annually for the purpose of 76(4) of the Act.

In October 2018, training records were received from the Director of Care (DOC). A course completion form for Abuse policy training was provided to the Inspector, and the documentation showed that 89 out of 97 (92 percent) of all staff were trained on the home's Abuse policy. It was then identified by the Inspector, that 97 was not an accurate total for all staff employed by the home in 2017. On a later date in October, 2018, additional training records were provided to the Inspector by the DOC, which stated that 93 out of 106 (87.7 percent) of all staff employed in the home in 2017, were trained on the home's Abuse policy. This was confirmed by the DOC.

However, it was identified when the Inspector asked for the actual training material,

the DOC showed the Inspector that staff were actually being trained on a February 2005 abuse policy, which had been created prior to the new legislation in 2007.

During interview with staff #138 on the Inspector confirmed that a third party learning module had been started in the home in 2014. Staff #138 then confirmed that they had along with a former Administrator (who had left the home a few years earlier), set up the training material in the third party learning module. During interview with staff #138, the Inspector was unable to verify who had actually set up the learning module in regards to the Abuse policy. The RAI Coordinator was then asked by the Inspector to view the Abuse policy training material. The RAI Coordinator confirmed that staff were being trained on a February 2005 abuse policy.

In an interview with the DOC, it was confirmed that all staff in the home did not complete annual retraining on the duty under section 24 to make mandatory reports or the home's policy to promote zero tolerance of abuse and neglect of residents and staff were not trained using home's current abuse polices.

Please note that this area of non-compliance was identified during CIS Inspection's log #002043-18 and CIS Inspection log #025848-17. [s. 76. (4)]

3. The licensee failed to ensure that all staff who provide direct care to residents, as a condition of continuing to have contact with residents, receive training in 1. Abuse recognition and prevention 2. Mental Health issues, including caring for persons with dementia,3. Behaviour management at intervals provided for in the regulations and 6. Any other areas provided for in the regulations.

In accordance with O. Reg. 79/10, s. 221. (2) 1., the licensee was required to retrain all direct care staff in the home annually. In accordance with O. Reg. 79/10, s. 221. (2) 2, the licensee did not assess the individual training needs of staff members as was confirmed by the DOC during an interview.

A) The licensee failed to ensure that all staff who provided direct care to residents received training in abuse recognition and prevention.

Documents provided and confirmed by the DOC in November 2018, indicated that not all staff who provided direct care to residents in 2017, received training in the area of abuse recognition and prevention. Training records provided confirmed that

of the 60 staff in the home who provided direct care to residents in 2017, 58 (97%) of those staff had not received the required training in the 2017 calendar year. (583)

B) The licensee failed to ensure that all staff who provided direct care to residents received training in metal health issues, including caring for persons with dementia and behaviour management.

i) The DOC provided 2017 training records for three "courses" that made up the training provided to staff related to the area of mental health issues, including the care for a person with dementia. During an interview with the DOC in October 2018, they verified their hand written notes made on the document provided were accurate and confirmed that in 2017 they had 70 staff members who provided direct care to residents, as well as the accuracy of the percentages of staff who received the training.

Documents provided by the DOC indicated that:
- For the course "Working with Dementia", 6 out of 70 staff (12.9%) had not received the training.
- For the course "Calming and comforting a person living with dementia", 5 of 70 staff (7.1%) had not received the training.
- For the course "10 ways to de-escalate" 6 of 70 staff (8.6%) had not received the training.

The DOC and training records confirmed that not all staff who provided direct care to residents in 2017 received training in the area of care for a person with dementia.

ii) During an interview with the DOC in October 2018, they reviewed training records for the 2017 calendar year and verified that training in the area of behaviour management had not been provided to staff who provided direct care to residents. (129)

C) The licensee failed to ensure that all staff who provided direct care to residents received training in any other areas provided for in the regulations.

i) The licensee failed to ensure that direct care staff received annual training in the area of skin and wound management.

In accordance O. Reg. 79/10, s. 221(1) 2 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of Skin and Wound Management. Documents provided and confirmed by the DOC indicated that not all staff who provided direct care to residents in 2017, received training in the area of skin and wound management. Training records provided at the time of this inspection confirmed that of the 62 staff in the home who provided direct care to residents in 2017, 38 (61 %) of those staff had not received the required training in the 2017 calendar year. (506)

ii) The licensee failed to ensure that all staff who provided direct care to residents received annual training in the area of falls prevention management.

In accordance O. Reg. 79/10, s. 221(1) 4 and 219 (1) the home is required to provide all staff who provide direct care to residents with annual training in the area of falls prevention and management.

Documents provided and confirmed by the DOC on October 11, 2018, indicated that not all staff who provided direct care to residents in 2017 received training in the area of falls prevention and management. Training records provided at the time of this inspection confirmed that of the 62 staff in the home who provided direct care to residents in 2017, 50 (81%) of those staff had received the required training in the 2017 calendar year. (506)

iii) The licensee failed to ensure that all staff who provided direct care to residents received annual training in the areas of skin and wound management.

In accordance O. Reg. 79/10, s. 221(1) 2 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of Skin and Wound Management. Documents provided and confirmed by the DOC indicated that not all staff who provided direct care to residents in 2017, received training in the area of skin and wound management. Training records provided at the time of this inspection confirmed that of the 62 staff in the home who provided direct care to residents in 2017, 38 (61 %) of those staff had not received the required training in the 2017 calendar year. (506)

iv) The licensee failed to ensure that staff who provided direct care to residents

received annual training in the areas of continence care and bowel care.

In accordance O. Reg. 79/10, s. 221(1) 3 and 219 (3) the home is required to provide all staff who provide direct care to residents with annual training in the area of continence care and bowel management.

Documents provided and confirmed by the DOC in November 2018 indicated that not all staff who provided direct care to residents in 2017, received training in the area of continence care and bowel management. Training records provided at the time of this inspection confirmed that of the 62 staff in the home who provided direct care to residents in 2017, 29 (47 %) of those staff had not received the required training in the 2017 calendar year. (583) [s. 76. (7)]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to residents. The scope of the issue was a level 3 as it related to education not being completed in full for all area reviewed. The home had a level 3 compliance history as they had related non-compliance that included:

- Voluntary plan of correction (VPC) issued for s. 76(6) issued July 12, 2017 (2017_574586_0012)
- VPC issued for s. 76(4) and s. 76(7)(4) issued February 17, 2017 (2017_573581_0002) (583)

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 015

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

Pursuant to / Aux termes de :

O.Reg 79/10, s. 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:

1. Communication of the seven-day and daily menus to residents.
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council.
3. Meal service in a congregate dining setting unless a resident's assessed needs indicate otherwise.
4. Monitoring of all residents during meals.
5. A process to ensure that food service workers and other staff assisting residents are aware of the residents' diets, special needs and preferences.
6. Food and fluids being served at a temperature that is both safe and palatable to the residents.
7. Sufficient time for every resident to eat at his or her own pace.
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.
9. Providing residents with any eating aids, assistive devices, personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.
10. Proper techniques to assist residents with eating, including safe positioning of residents who require assistance.
11. Appropriate furnishings and equipment in resident dining areas, including comfortable dining room chairs and dining room tables at an appropriate height to meet the needs of all residents and appropriate seating for staff who are assisting residents to eat. O. Reg. 79/10, s. 73 (1).

Order / Ordre :

The licensee must be compliant with O. Reg. 79/10, s. 73. (1) 9 of the LTCHA.

Specifically the licensee must:

1. Ensure all residents in the home are provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

2. Ensure residents who require extensive and total feeding assistance at morning, afternoon and evening nourishment times are provided the assistance they require with foods and fluids.

3. Develop and implement an auditing system to identify if residents are getting the assistance they require at both the dining and snack service. Maintain records of of these audits.

4. Develop and implement a staffing plan for each dining room that provides for a staffing mix that meets residents' assessed care and safety needs during dining services. Maintain a written record of this plan.

Grounds / Motifs :

1. The licensee failed to ensure that residents were provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible.

A) During a meal service observation on an identified date during the inspection, resident #006 was observed with their entrée in front of them from for 30 minutes when they were then provided with cueing to eat. PSW #100 then cut the resident's food, but they only ate one bite, then the PSW didn't encouraged the resident to eat again for another 20 minutes. The resident was served dessert which they ate in full. Ten minutes later, RPN #102 encouraged the resident further, and they began eating some more of their entrée but staff failed to offer resident their special nutrition intervention as directed in the plan of care.

Resident #006's was assessed to be at nutritional risk and their plan of care directed staff to provided encouragement at meals. This was confirmed in an interview with

RPN #102 and it was confirmed resident #006 did not receive the encouragment and assistance they required during the meal service. (586)

B) A meal service observation was completed on an identified date during the inspection. PSW #119 was alone in the dining room with 12 residents. The PSW was observed assisting residents #003, #004 and #006 with eating. The PSW indicated that all three residents needed to be fed their meals and beverages that day. They also indicated that there were three other residents in the dining room that required intermittent assistance. The PSW was observed going between two tables assisting residents #003, #004 and #006 as well as the other resident who required intermittent feeding assistance. Resident #002's food sat in front of them for 45 minutes and the PSW indicated that they had not had time to assist the resident yet.

Resident #003's documented plan of care indicated that they required assistance with eating. In an interview with the RD, they confirmed that resident #004 required assistance with eating. It was confirmed the resident was not provided the feeding assistance they required. (586)

C) i) A meal service was observed on an identified date during the inspection. PSW #119 was alone in the dining room with 13 residents. The PSW was observed assisting residents #002, #003, #004 and #005 with eating. The PSW indicated that all four residents needed to be fed their meals and beverages that day. The PSW was observed going between two tables giving each residents a few bites of their food before moving onto the next resident, in addition to clearing other residents' plates and serving them their dessert. The PSW was standing beside the residents while feeding them rather than sitting. The PSW indicated that they were aware they were not supposed to be assisting multiple residents; however, due to the lack of staffing, they were required to assist all four residents simultaneously.

Resident #003's documented plan of care indicated that they required assistance with eating. In an interview with the RD, they confirmed that resident #004 required assistance and it was confirmed the resident did not get the assistance they required with feeding. (586)

ii) A meal service was observed on an identified date during the inspection on the second floor. PSW #119 was alone in the dining room with 13 residents. The PSW

was observed assisting residents #003, #005, #002 and #004 with eating. The PSW was observed going between two tables giving each residents a few bites of their food before moving onto the next resident, in addition to clearing other residents' plates and serving the remainder of the dining room their dessert. The PSW was observed encouraging resident #003 to have some of their fluids; however, this was not done for the other residents. When all residents were finished their meals, resident #003 had one 250 ml glass of fluid and one 250ml glass of another fluid remaining that they had not consumed. Resident #004 had two 250 ml glasses remaining that they had not consumed, though the resident had attempted to drink these themselves throughout the meal without success. Resident #005 had two 250 ml glasses of fluid remaining that they had not consumed, though the resident had attempted to drink these themselves throughout the meal without success.

Resident #003's, #004's and #005's documented plan of care indicated they were at nutritional risk and that they required assistance with feeding.

PSW #119 confirmed that resident #003, #004 and #005 did not get the personal assistance and encouragement required and were not provided there required amounts of fluids. They were the only front line staff present during the meal service and shared they were short staffed. (586)

Please note that this area of non-compliance was identified during Complaint inspections.

C) During an observation on a specified date during the inspection, two residents were observed sitting in an identified area and no staff were present.

Resident #004 had a full container of puree snack with a spoon in it and a full beverage which was in a double handled mug with a lid on it and it was observed to be on the floor in front of the resident. Resident #004 was at nutrition risk and required assistance and supervision while eating due to risk related to their medical diagnosis.

Resident #002 had a puree snack and beverage. No beverage was taken and the snack was spilled and on its side with a spoon in it. The Inspector asked if the resident could take a spoon of the snack and they were unable to feed themselves at the time of my observation. Resident #002 was at nutrition risk and was assessed to

require monitoring when eating due to risk related to their medical diagnosis. The plan of care directed staff to provide cueing and feeding assistance with eating.

It was confirmed with the Administrator, that only two out of five scheduled PSW's were working on the floor at the time of the observation. It was confirmed that resident #002 and #004 were not provided with the personal assistance and encouragement required to safely eat and drink as comfortably and independently as possible. (583)

Please note that this area of non-compliance was identified during Complaint inspections.

D) During an observation on an identified date and time during the inspection, a resident room was observed and two residents were observed with food at their bedside with no staff present. No food was taken.

Resident #025 had a full thickened beverage at their bed side and no snack. Resident #025 was assessed at nutrition risk. The plan of care identified the resident required feeding assistance with eating.

Resident #046 had a full beverage and pureed snack at their bedside. Resident #046 was assessed at nutrition risk. The plan of care directed staff to monitor the resident while eating due to risk related to their medical diagnosis.

In an interview with PSW #119 and #132, it was confirmed that resident #025 and #046 were not provided with the personal assistance and monitoring required to safely eat and drink as comfortably and independently as possible. During the interview it was shared the snacks and beverages were handed out at during snack service but the staff were unable to provide feeding assistance to residents that required assistance with eating due to short staffing. It was confirmed that none of the residents who required feeding assistance with their beverage or food were provided assistance on the floor. (583)

Weight reports over an identified period were evaluated for the residents noted above who were identified as not having received the assistance they required from staff for feeding. It was documented that resident #002, #003, #004, #006, #016, #046 and #063 all had ongoing monthly weight loss over an identified time period. It

was noted that resident #004 loss greater than 7.5 percent of their body weight over an identified period and that resident #002 and #046 lost greater than 10 percent of their body weight in an identified period. [s. 73. (1) 9.]

The severity of this issue was determined to be a level 2 as there was potential for actual harm to the residents. The scope of the issues was determined to be a 2, a pattern. The home had a level 3 compliance history as they had on going related non-compliance that included:

- Written notification (WN) for r. 73. (1) 2 issued February 23, 2016 (2015_188168_0031)
- WN for r. 73. (1) 1 issued February 23, 2017 (2017_573581_0002)
- WN for r. 73. (1) 2 issued February 23, 2017 (2017_573581_0002)
- WN for r. 73. (1) 9 issued February 23, 2017 (2017_573581_0002) (583)

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 26th day of March, 2019 (A4)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur :

Amended by KELLY HAYES (583) - (A4)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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