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 le Loi de 2007 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 de permis

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
May 24, 2018;	2018_605213_0005 (A1)	027582-17, 000055-18, 000598-18, 000805-18, 001888-18, 002773-18, 005174-18	Complaint

Licensee/Titulaire de permis

Craigwiel Gardens
221 Main Street R. R. #1 AILSA CRAIG ON N0M 1A0

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

Craigholme
221 Main Street, R.R. #1 AILSA CRAIG ON N0M 1A0

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

Ontario

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Amended by RHONDA KUKOLY (213) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The compliance dates for Compliance Orders #001, #002 and #003 have been changed from June 4, 2018 to July 6, 2018, at the request of the home's Acting Administrator.

Issued on this 24 day of May 2018 (A1)

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

Original report signed by the inspector.

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

Amended by RHONDA KUKOLY (213) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): March 21, 22, 23, 26, 27, 28 & 29, 2018.

This inspection was completed related to the following seven complaints:

Log #027582-17, Infoline # IL-54355-LO, related to the home's complaints process and care concerns.

Log #000055-18, Infoline # IL-54794-LO, related to shortage of staff and care concerns.

Log #000598-18, Infoline # IL-54891-LO, related to shortage of staff, care concerns, skin and wound care and falls prevention.

Log #000805-18, Infoline # IL-54936-LO, related to shortage of staff and care concerns.

Log #001888-18, Infoline # IL-55162-LO, related to shortage of staff and care concerns.

Log #002773-18, Infoline # IL-55361-LO, related to shortage of staff and care concerns.

Log #005174-18, Infoline # IL-56012-LO, related to shortage of staff, care concerns, falls prevention, and abuse and neglect.

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

Administrator, the Director of Care, the Assistant Director of Care, the Environmental Services Manager, the Food Services Manager, a Registered Dietitian, Registered Nurses, Registered Practical Nurses, Personal Support Workers, Dietary Aides, Housekeeping Aides, Activation Staff, Administrative Assistants, residents and family members.

The Inspectors also made observations of residents, meals, activities and care. Relevant policies and procedures, meeting minutes, incident reports, as well as clinical records and plans of care for identified residents were reviewed. Inspectors observed resident/staff interactions, infection prevention and control practices.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management

Dining Observation

Falls Prevention

Hospitalization and Change in Condition

Nutrition and Hydration

Reporting and Complaints

Skin and Wound Care

Sufficient Staffing

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

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

WN #1: The Licensee has failed to comply with LTCHA, 2007, s. 6. Plan of care
Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

The Ministry of Health and Long-Term Care received a complaint, which included a concern related to falls prevention.

The following observations were completed during the inspection:
- On an identified date and time, resident #006 was walking in the hallway. In the resident's room, there were two side rails in use. There was a sign above the bed that indicated days: one rail, nights: one rail, right side.
- On another identified date and time, resident #006 was observed lying in bed with two side rails in use. There was a sign above the bed that indicated days: one rail, nights: one rail, right side.
- On another identified date and time, resident #006 was walking in the hallway. In the resident's room, there were two side rails in use. There was a sign above the bed that indicated days: one rail, nights: one rail, right side.

The care plan in Point Click Care (PCC) for resident #006 was reviewed and showed:
- Bed Safety: 1 bed rail
- Number side rails as per assessment/resident preference refer to over bed logo

Assessments in PCC for resident #006 were reviewed. The last "Bed Rail Assessment" indicated: One side rail for bed mobility and positioning assistance.

The home's policy "Bedrails", with a revision date of March 2016, was reviewed. The policy indicated: "Use of bed rails should be based on residents' assessed medical needs and should be documented clearly and approved by the interdisciplinary team".

In an interview with the Assistant Director of Care (ADOC) and Inspector #689, the ADOC agreed that two side rails were in use and that the sign above the bed indicated one side rail on the right side to be used days and nights. They said they were not sure whether the bed rails that were in use were correct, or if the signage was correct.

The licensee has failed to ensure that the care set out in the plan of care, related to the use of side rails for resident #006, was provided to the resident as specified in the plan. [s. 6. (7)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 001

WN #2: 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 written staffing plan (including the back-up plan for nursing and personal care staffing that addresses situations when staff, cannot come to work); for the programs including Personal Care, Bathing, Foot Care and Nail Care, Dress, Bedtime and Rest Routines; provided for a staffing mix that was consistent with residents' assessed care and safety needs

and that met the requirements set out in the Act and the Regulations.

The Ministry of Health and Long-Term Care received six complaints during a ten week period, related to concerns about the home being short staffed, including multiple care concerns.

A review of the "Staffing Planning" policy with a revised date of April 2017 was completed. The daily pattern unit included:
Days:
Registered Nurse (RN) – 1
Registered Practical Nurse (RPN) – 3
Personal Support Worker (PSW) – 9

Evenings:
Registered Nurse – 1
Registered Practical Nurse – 3
Personal Support Worker - 9

Nights:
Registered Nurse – 1
Registered Practical Nurse – 0
Personal Support Worker – 3

The home's staffing schedules were reviewed for a five week period of time. The number of day shifts of PSWs capable of fulfilling full resident care needs over a 37 day period were as follows:
- 3 ½ worked shifts out of 9 planned shifts on 1 day.
- 4 worked shifts out of 9 planned shifts on 12 days.
- 5 worked shifts out of 9 planned shifts on 6 days.
- 5 ½ worked shifts out of 9 planned shifts on 1 day.
- 6 worked shifts out of 9 planned shifts on 13 days.
- 6 ½ worked shifts out of 9 planned shifts on 1 day.
- 7 worked shifts out of 9 planned shifts on 3 days.

The "Staffing Contingency Plan" was reviewed and indicated direction and routines as follows:
1 PSW short: 8 PSW
2 PSW short: 7 PSW
3 PSW short: 6 PSW

4 PSW short: 5 PSW
5 PSW short: 4 PSW

For 3 PSW Short: 6 PSW
- Follow 6 Aide assignment in Point of Care (POC) – each staff assigned 14 residents
- Night staff to complete am care and dress a minimum of 6 residents (list at desk of residents who will have minimum impact of being woken early)
- Registered staff to assist with care and transfers as able. RN to assist with care before breakfast if full RPN staff.
- Consider offering bed baths as time allows
- Ask other departments to assist with portering and feeding in dining room

4 PSW Short: 5 PSW
- Follow 5 Aide assignment in POC – Top and Bottom pick up from Middle assignment
- Night staff to complete am care and dress a minimum of 9 residents (list at desk of resident who will have minimum impact of being woken early)
- RN to assist with care before breakfast if full RPN staff
- Ask other departments to assist with portering and feeding in dining room
- Paper Food and Fluid record to be used – any staff can assist in completing and registered staff will enter into POC
- Dietary staff to serve in dining room (evening shift)

For 5 PSW short: 4 PSW
- RN to assign one RPN to the floor and 2 RPN to complete med pass for home
- RN and RPN to assist with resident care on the unit
- "pyjama day" if residents agree, may go to dining room for breakfast in housecoat or if evening shift, change residents as the y agree into pyjamas after lunch
- if morning shift short, night staff to complete am care and dress a minimum of 12 residents
- ask other department to assist with portering residents and feeding in dining room
- one dietary staff and one PSW to complete snack cart
- dietary staff to serve in dining room (evening shift)

A review of "Craigwiel Gardens Staffing Vacancies", provided by the Director of Care #100 was completed and indicated:
Part time RN – 3 Positions
Part time RPN – 1 Position

Temporary Part Time RPN – 1 Position
Temporary Full Time PSW – 3 Positions
Full Time PSW – 1 Position
Scheduled Part Time PSW – 1 Position
Part Time PSW – 5 Positions
Temporary Part Time PSW – 3 Position
Weekend Worker PSW – 1 Position

A record review of the documentation of complaints received by the home was completed. The three complaints were reviewed and included:
- On an identified date, a complaint regarding resident #022 indicating that the resident had not received a bath or had bedding changed in weeks. The resident had been found during the night still to be up in their chair and asking to go to bed. In addition, their roommates had asked, for up to two hours, for assistance, with no staff assistance provided. The complaint stated that this was unacceptable and was because there was no staff. The complaint further stated that during an outbreak, resident #022 had not received a bath, a bed bath or sponge bath, or had bed linens changed for three weeks. Documentation included a phone call with the complainant on an identified date. Documentation of the investigation included: "While it is true that we have not had the same complement of staff on the floor as usual due to staffing challenges, we are faced with barriers in our efforts. We have been in two outbreaks (one for respiratory lasting 30 days) and one for Influenza A lasting two weeks. During any outbreak, we do not put residents in the tub for infection control purposes. While it is possible that they may have not had a bath, it is also possible that they had bed baths while in outbreak."
- On another identified date, a complaint regarding resident #022 indicated that the resident had not received a bath and was supposed to have two baths per week. The outcome documented included that the resident received a bath the following day. The subsequent day, it was not reported that baths were missed. Missed baths were brought to the attention of the Administrator at a family council meeting. The Administrator spoke to the Director of Care (DOC) and requested a plan be put in place to address missed baths in time of short staffing situations.
- On an identified date, a complaint regarding resident #001 indicated that the resident had not received care, i.e. shaving and bathing.

A review of "Residents' Council Meeting Minutes" was completed. One identified meeting had eight residents documented in attendance and the Residents' Council Assistant was documented as being the Director of Care and the Administrative Assistant. Under "Home Areas Updates and Discussion", for Nursing and Personal

Care, the minutes stated: "Very happy with the staff, staff are very good to them. Have noticed that sometimes the beds are not getting made, they know that the staffing level is low. We are doing everything we can to recruit new staff, hope to get some new people in soon. Have been interviewing and advertising."

The following memos were noted in the staff communication book:
- We are continuing to have challenges with staffing. Ongoing recruitment is happening but unfortunately takes time. I have said before, it is important to be sure we get the right people in to work here and not just anyone. As recruitment goes on, we have a duty to continue to provide care for residents. It is not acceptable to not do any baths because we do not have full staff. When we are working short, residents can be offered a bed bath or shower instead of a tub bath. Also, when working short staffed in the evening, we still need to work with the dietary staff to ensure that the resident meals are served. Saying we will not serve soup is not appropriate for the residents and a waste of food. When working short, it is the responsibility of the RN to coordinate with all staff on to ensure that resident care is completed. It is expected that RN and RPN staff will assist with personal care as needed.
- If we are doing a bed bath for a resident and we are counting it as their bath for the day, we are able to use the bath in a bag and the hair wash caps. Please be sure that it gets documented in POC as their bath.
- Because of short staffing, bowel movements are not always getting charted. Please ask your PSW's before giving laxatives.
- To the night staff from an identified date. The day staff would like to thank you for all of your awesome help for the residents Saturday morning. It was truly appreciated!
- Our ongoing staffing crisis is a challenge to everyone. It is times like this that it is more important than ever that we work together to provide the best possible care for all of our residents. This means registered staff stopping during their med pass to assist with a transfer.

On an identified date, the Point of Care "Shift Dashboard" in Point Click Care (PCC) was reviewed, specifically, the "Alerts Triggered in the last 24 hours". The documentation showed the following:
05:55 Resident #023 washed and dressed by night staff
05:54 Resident #021 washed and dressed by night staff
05:54 Resident #031 washed and dressed by night staff
05:54 Resident #027 washed and dressed by night staff
05:54 Resident #029 washed and dressed by night staff

05:53 Resident #015 washed and dressed by night staff
05:53 Resident #008 washed and dressed by night staff
05:42 Resident #012 washed and dressed by night staff
05:41 Resident #032 washed and dressed by night staff
05:41 Resident #033 washed and dressed by night staff
05:40 Resident #034 washed and dressed by night staff
05:39 Resident #030 washed and dressed by night staff
05:39 Resident #014 washed and dressed by night staff
05:38 Resident #035 washed and dressed by night staff
05:37 Resident #009 washed and dressed by night staff
Fifteen residents were documented as washed and dressed by night staff on the identified date, with the documentation completed between 0537 hours and 0555 hours.

The home's bath schedules and the Point of Care documentation for bathing completed for a four week period of time, were reviewed in PCC by Inspector #689. Given the understanding that the following residents requested to have two baths per week, documentation of resident baths over the four week period was noted as follows:
- Resident #001: 3 out of 8 opportunities (38 per cent), there was no bath documented.
- Resident #004: 6 out of 8 opportunities (75 per cent), there was no bath documented.
- Resident #005: 4 out of 8 opportunities (50 per cent), there was no bath documented.
- Resident #006: 2 out of 8 opportunities (25 per cent), there was no bath documented.
- Resident #007: 3 out of 8 opportunities (38 per cent), there was no bath documented.
- Resident #009: 4 out of 8 opportunities (50 per cent), there was no bath documented.

A record review of POC documentation in PCC was completed. Documentation related to recording of resident bowel movements was noted as follows:
- Resident #001: 17 out of 30 dates (56 per cent) did not have any documentation of bowel movements on every shift.
- Resident #005: 14 out of 30 dates (46 per cent) did not have any documentation of bowel movements on every shift.
- Resident #008: 23 out of 30 dates (76 per cent) did not have any documentation

of bowel movements on every shift.

A record review of POC documentation in PCC was completed. Documentation related to recording of resident intake of meals was noted as follows:
- Resident #008: 49 out of 90 of meal times (54 per cent) did not have any documentation of intake.
- Resident #019: 25 out of 90 meal times (28 per cent) did not have any documentation of intake.
- Resident #020: 22 out of 90 meal times (24 per cent) did not have any documentation of intake.

Observations of the lunch meal service by Inspector #689 on an identified date, identified one staff member provided feeding assistance to four residents in the dining area at the same time.

Observations of the lunch meal service by Inspector #689 on an identified date, identified resident #017 being served their meal with no staff present. The resident was not able to eat unassisted. Eight minutes later, the resident was assisted with feeding the meal that had been served.

Observations on an identified date, between 0845 hours and 0950 hours identified the following:
- The Director of Care (DOC) and the Administrator were observed helping feed and assist in the dining room
- The Chaplain, activation staff and other plain clothes staff were observed assisting with portering residents to and from the dining room and with feeding residents in the dining room
- Housekeeping staff and maintenance staff were observed assisting with portering residents to the dining room
- PSW staff were observed feeding in the dining room, as well as, assisting residents with personal care in rooms and portering them to the dining room. At 0850 hours, a staff member brought a resident into the dining room and said to another staff member you need to get [a resident] up, they're not up yet, the Staff Member responded they're not up? Okay. The staff member left the dining room.

Observations of the morning meal service on another identified date, at 0904 hours, identified one staff member going back and forth between two tables in the dining area to provide assistance with feeding four residents at the same time.

Observations of the morning meal service on another identified date, at 0846 hours, identified one staff member providing assistance with feeding three residents at one table in the dining area at the same time.

Observations of the morning meal service on an identified date, at 0853 hours, identified resident #016 was served oatmeal, eggs and toast with no staff available to assist with feeding. At 0859 hours, the resident was asked by the Administrator if they needed help. The resident was then removed from the dining area by another staff member and at 0904, the resident was brought back into the dining area and the DOC assisted the resident with feeding the meal that had been served at 0853 hours.

Observations on another identified date, at 0850 hours identified the following:
- During the breakfast meal, the Assistant Director of Care (ADOC) and the Administrator were observed feeding and assisting in the dining room
- Housekeeping staff and maintenance staff were observed assisting with portering residents to the dining room
- PSW staff were observed feeding in the dining room, as well as still, assisting residents with personal care in rooms and portering them to the dining room

Observations on an identified date between 0935 hours and 1035 hours identified the following:
- 0935 hours: Resident #006 was walking from the direction of the dining room to their room down the hall and was wearing pyjamas, a housecoat/robe and slippers.

- 0937 hours: Resident #006 was observed in bed wearing pyjamas and a robe, lying under the covers.
- 0940 hours: Inspector #213 asked Staff Member #106 why resident #006 was still wearing night clothes and a robe. The Staff Member said that it was because the staff didn't have time to provide care for the resident yet that morning, so they put a robe on so they could go for breakfast. The Inspector asked if the resident was scheduled for a bath that day, and the Staff Member said no.
- 1035 hours: Resident #006 was observed lying in bed still wearing pyjamas and robe on, under the covers.

Observations conducted on an identified date, between 1446 hours and 1519 hours with Inspector #213 and #689 identified the following:
-Resident #012 was in a lounge with the TV on, sitting in a wheelchair. The resident’s finger nails were long and uncut, they were unshaven with several days’

hair growth, and their shirt was soiled with a yellowish substance, a large area approximately the size of a grapefruit.
-Resident #025 was in their room. The resident's fingernails were clean, but uncut.
-Resident #005 was in their room in bed. The resident's fingernails were clean, but uncut.
-Resident #026 was in their room sitting on the bed. The resident's fingernails were clean, but long and uncut.
-Resident #027 was in the lounge near the nursing station sitting in a manual wheelchair. The resident's hair was unkempt and their nails were long, chipped and broken.
-Resident #028 was in the hallway sitting in a wheeled chair. The resident's nails were soiled under the nail, long and uncut.
-Resident #004 was sitting in their room in a wheeled chair. The resident's hair was messy and unkempt, and their nails were long and uncut.
-Resident #011 was in their room. The resident's nails were long and chipped, but painted.

Observations conducted three days later, at 1415 hours by Inspector #213 identified the following:
-Resident # 012 was in their room in bed sleeping. The resident's fingernails were clean, but still long and uncut.

Observations conducted the following day, between 0950 hours and 1505 hours by Inspector #213 identified the following:
-Resident #025 was in a hallway in a wheelchair self-propelling to their room after breakfast. The resident's fingernails were clean, but still long and uncut.
-Resident #012 was in a lounge with a TV in the lower unit. The resident was unshaven, had a shirt soiled with food, and had fingernails with dirt under the nail and still uncut.
-Resident #026 was in their room sitting in a lazy boy chair with the TV on and eyes closed. The resident's fingernails were still long, right thumb nail was specifically long, broken and chipped.
-Resident #028 was in their room sleeping. The resident's fingernails were long, had dirt underneath and still uncut.
-Resident #004 was in their room sitting in a wheeled chair. The resident's hair was messy and unkempt, fingernails were still long and uncut.

In an interview with a Staff Member, the Staff Member said that the home is always short staffed for personal support workers (PSWs). The staff said that night staff

had been expected to assist with resident morning care when the morning shift was short staffed. They said that the night staff usually started morning care for residents between 0430 hours and 0500 hours, depending on how many residents they got up. When asked if baths were getting completed, the Staff Member answered no, baths were not getting completed. The Staff Member said that if a bath or a shower was not completed, the staff were told to document that the resident had a bed bath, even if the resident just had regular morning care. When asked if staff were always getting documentation completed, the Staff Member said no. When asked how long the staffing had been a problem, they said since before Christmas, to date. They said it's not fair for the residents, they're not getting proper care. When asked if there was enough staff to feed the residents, they said no, they're getting cold meals. When asked how many residents the staff were providing feeding assistance to, they said there's one staff for four residents requiring feeding assistance. The Staff Member said that they're late getting to the dining room for breakfast and lunch because they're still getting people up.

In an interview with another Staff Member, the Inspector asked the Staff Member if they were short staffed that day, and the staff answered yes. The Inspector asked how many staff they had that day, and they said six in total, five on the floor with one staff assigned to complete baths. The Inspector asked if the home was having issues with short staffing, and the staff answered yes. When asked how long this had been a problem, the staff responded since before Christmas. The Staff Member shared that the lowest staffing they had experienced was three PSWs on the floor on days, and when that happened, they would pull a registered practical nurse (RPN) to work on the floor and potentially call in a registered nurse to cover the RPN shift. The Staff Member said that the DOC and Administrator have both helped with portering residents to and from the dining room and assisting with feeding. When asked if baths were getting done, the Staff Member said no, that they have been trying to get a bed bath in, but rarely, and that it had been affecting nail care as well. When asked if other resident care has been affected, the Staff Member answered, in general hair washing and nails. The Inspector stated that the chaplain, activity staff and managers were observed helping with breakfast service that day and asked the Staff Member if that was usual. The Staff Member said the chaplain portered residents to and from the dining room, and the activity staff helped with feeding. They said that occasionally the Administrator assisted as well, but not every day. When asked what happened on the weekend when all of the support staff were not in the home, the Staff Member said that they relied on dietary to help porter. They said that housekeeping staff would also help when necessary. The Inspector asked if staff have needed to feed more than two

residents at a time, and they said yes. When asked if all documentation had been completed, they answered no, not always. The Inspector asked the Staff Member if they remembered a day when they did not work short staffed. The Staff Member answered no.

In an interview with another Staff Member, when asked if the nursing shortages were affecting dietary service, they answered yes. When asked how long this had been an issue, they said for a long time and had been short for months, since Christmas time. The Staff Member said that they and the dietary staff were helping with portering residents to and from the dining room and feeding residents. The Staff Member said that it did affect the dietary department with the residents getting into the dining room late, sometimes on weekends not until 0950 hours and breakfast was supposed to start around 0800 hours. They said that when breakfast was late, everything else for the rest of the day was late, including the morning snack cart.

In an interview with another Staff Member, when asked if the nursing staffing shortages were affecting dietary service, they said nursing staffing affected everyone. They said dietary aides and cooks assisted with porting residents to the dining room for breakfast. The Staff Member said that one dietary staff would collect and help feed the residents, but they couldn't help them out of bed. When asked if they have had training on how to properly feed residents, the Staff Member answered no. The Staff Member said that because residents were getting to the dining room later, the meals were starting later. They said that this made it hard for dietary staff to clear tables, because they couldn't move carts around to clear as people were still eating. The Staff Member further said that they couldn't get all the dishes done, which put the routine behind with snack service.

In an interview with another Staff Member, the Inspector asked if the home was having issues with short staffing and they answered yes, particularly PSWs. When asked how this was affecting resident care, they answered that it was affecting care; baths had not been getting done twice a week. The Staff Member said that staff had to pick and choose what care was done, because there were not enough bodies. When asked what care besides baths had been affected, the Staff Member said residents were leaving the dining room without having their mouth washed, mouth care was not done, toileting schedules were not followed, residents were staying in a wet brief longer than they would have, and nail care was not getting done because nails get done in the bath. The Inspector asked if staff were completing all documentation as required and resulting impacts. The Staff Member

shared that residents had potentially received a laxative when it wasn't necessary, because bowel movements were not documented. They said low fluid referrals had also been made because fluids weren't documented.

In an interview with a non-nursing Staff Member, the Staff Member stated that it was a requirement of their job to feed residents one meal a day during their shift. The Inspector asked if they had received training related to feeding residents, and they answered no. They said that they helped to feed three of the four residents at one particular table in the dining area, but the fourth resident was needing more assistance and asked for help. The Staff Member stated they would go around the table to all four residents the best they could using a wheeled stool.

In an interview with another Staff Member, when asked if nights got residents up that morning, they answered yes. They said there were six residents up in the middle wing alone that day and they were washed, dressed, and up in their chairs at 0600 hours that morning when day staff arrived.

In an interview with another Staff Member on that date, they said that there were five PSWs working days that day.

In an interview with the DOC, the Inspector asked if the home had staffing issues recently, the DOC said yes, serious staffing issues. The DOC said there are issues at all levels, but they were really short on PSWs.

In an interview with the DOC on another date, the Inspector asked about the contingency plan where it stated: for five PSWs on; four PSWs short, that night staff are to get nine residents washed and dressed, the DOC answered yes. The Inspector asked what time they start getting residents up on nights, and the DOC said about 0515 hours. The Inspector asked if the night shift is done at 0600 hours, the DOC said yes. The Inspector asked how the staff could get nine residents washed and dressed in less than 45 minutes. The DOC said that there are four staff on night shift and that they didn't necessarily get residents up in their chairs, just washed and dressed in their beds.

In an interview with the DOC on another date, the Inspector asked if bed baths were being counted as tub baths. The DOC said staff could give a bed bath, tub bath, or shower, depending on the resident's plan of care. The DOC said the problem with bed baths was that resident's hair didn't get clean, but the home got the 'bath in a bag' with the 'hair caps' to get the residents' hair clean. The DOC

answered no, that a bed bath substituted for a tub bath was not the residents' method of choice for bathing, when asked by the Inspector.

In an interview with another Staff Member on another date, they said that there were five PSWs working that day with one of the five on modified duties, unable to complete all aspects of resident care. The Staff Member said that night staff got several residents washed and dressed that morning, and they had a list on paper of which residents were washed and dressed and it was also documented in Point Click Care (PCC) on the Dashboard.

In an interview with resident #011 on an identified date, Inspector #689 noted that the resident's nails were long and chipped, but painted. The Inspector verbally noted their painted nails and the resident said that their family had painted them. When asked if the staff cut their nails, the resident said, oh no, they didn't do that. The resident then said "they finally washed my hair today". Inspector #689 asked when was the last time they had their hair washed, and they said they didn't know, last week some time.

In an interview with a family member, the family member shared that their loved one in the home had missed three baths on specific dates, and then said that the resident had a make-up bath for one of the baths on an identified date.

In an interview by Inspector #689 with resident #022 on an identified date and time, when asked if they had any concerns with bathing, the resident said their family member and them had concerns with not getting a bath. The resident said that their first bath of the week would be missed and wouldn't get another bath until the end of the week. The resident was not able to remember when their bath was missed and said that their family advised them to write it down.

A review of the home's policy entitled "Medical Records Documentation" with a revision date of March 2016, stated Charting Procedure: "The following information shall be documented in the electronic medical record: Daily care documentation via Point of Care System".

A review of the home's policy entitled "Pleasurable Dining" with a revision date of March 2018 stated under procedures the following:
- No resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance by the resident.
- Staff assist no more than two residents at time with eating and/or drinking

A review of the home’s policy entitled “Nail Care”, with a revision date of March 2016, stated the following:
- All residents will have their fingernails cleaned and trimmed on bath day.
- Encourage resident to be as independent as possible and provide assistance as necessary.

A review of the home’s policy entitled “Bathing”, with a revision date of March 2016, stated the following:
- All residents will be bathed twice per week, by method of their choice on a regularly scheduled day.

The "Staffing Plan Craigwiel Gardens 2018 - 2019" with an evaluation date of March 2018, and a revised date of March 22, 2018, was reviewed after the Administrator provided this document indicating that this was the home's staffing plan evaluation. The evaluation included "goals to achieve the purpose", "indicators to monitor", "results against targets", and "new strategies to improve results". Under "results against targets" there were "time period (e.g. monthly, quarterly)" and "baseline", "target", and "result" fields. The entire "results against targets" field was blank for all goals with no baseline, targets to achieve, or target dates identified. No persons were identified as responsible for indicators or new strategies.

The licensee has failed to ensure that the written staffing plan and the back-up plan for nursing and personal care staffing provided for a staffing mix that was consistent with residents’ assessed care and safety needs and that met the requirements set out in the Act and the Regulations. The home was operating on their back-up plan every day, over a five week period of time. There were two to six less personal support workers working day shift than the staffing plan allotted. During this time, residents did not receive two baths per week, daily grooming and hygiene, nail care, assistance required for feeding, staff were feeding more than two residents at a time, documentation was not completed and numerous residents were being washed and dressed before 0530 hours. [s. 31. (3)]

Additional Required Actions:

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

(A1)The following order(s) have been amended:CO# 002

WN #3: 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).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents were offered a minimum of three meals daily.

The Ministry of Health and Long-Term Care received a complaint, which included a concern related to nutrition and hydration for a specified resident.

Observations on an identified date, between 0930 hours and 1000 hours:
- Resident #019 was in their room in bed during the breakfast meal.
- Resident #039 was in their room in bed during the breakfast meal.
- Resident #008 was in their room in bed during the breakfast meal.

Resident #008 was not offered breakfast. Inspector #689 asked resident #008 if they had breakfast and the resident shook their head no. The Inspector asked if they were offered breakfast and the resident shook their head no. The Inspector asked if they wanted to have something for breakfast and the resident nodded yes. Staff Member #106 indicated that this resident sometimes got breakfast and was not sure why dietary staff did not make a food tray. Inspector #689 informed the Staff Member that resident #008 said they wanted breakfast.

The plan of care for resident #008 was reviewed and indicated a regular diet and a

therapeutic diet.

In an interview with a non-nursing Staff Member, the Staff Member said that kitchen staff were not aware that resident #008 required tray service for meals. The staff further stated that they did not know if resident #008 had any meals or meal trays offered for a three month period of time. The Staff Member stated that meal offerings were falling through the cracks and said that one day, they noted that resident #038 was not in the dining room for breakfast and lunch, so the non-nursing staff themself sought out the resident and made sure the resident got supper that day. When asked what the process was for residents receiving meals who were not in the dining room, they said that the home’s policy stated that the nurse was to send a requisition to the kitchen staff requesting tray service for residents not able to go to the dining room.

In an interview, a Staff Member indicated that nursing staff were to send a requisition to the kitchen for residents that did not go to the dining room for a meal. The Staff Member identified that resident #015 was the only resident who regularly received set meal tray service. When asked about meals for resident #008, they said the kitchen did not receive a meal tray requisition for this resident.

On an identified date, a Staff Member said that resident #019 and resident #039 did not want to get up that morning for breakfast. Inspector #213 asked the Staff Member if these residents would be brought meal trays and the Staff Member said that the residents usually do not get trays when they do not want to get up; however, the residents would be given something off the morning snack cart.

In an interview with another Staff Member on another date, the Inspector asked if many residents stay in their room for breakfast and the Staff Member said that resident #019 never goes to the dining room for one identified meal. They said that this resident had milk and juice approximately two to three hours later. The Staff Member said they were not sure if the resident got juice that day. The Staff Member stated that resident #037 had gone to the dining room for that meal in many months and stays in their room. They said that the resident was happier and will be given juice, but is not provided or offered food.

In an interview with another Staff Member, the Inspector asked if resident #008 had been receiving meal trays prior to last week and the Staff Member answered no, the resident was getting specific items for breakfast, but they were not sure if the resident got anything on supper cart and did not get anything for lunch. They said

that resident #008 could get something off the snack cart, and usually chose water. When asked if residents were offered food if they do not get up for a meal, the Staff Member said residents #037, #019, #036 and #038 do not go to the dining room for a specific meal. They said that #038 got a granola bar and residents could get something off the juice cart. The Staff Member said resident #019 got drinks off the cart, and because this resident was diabetic, the staff were not comfortable with the resident not getting anything.

Observations on an identified date, from 0845 to 0915 hours:
- Staff Member #115, entered lower hallway with a cart consisting of 2 trays with juice, milk, water and medications, entered resident #019's room and provided fluids, oral medications and insulin to resident #019 who was in their bed. No food was delivered or offered to resident #019.
- Staff Member #115 entered resident #020's room and provided milk, juice, water and medication to resident #020 who was in their bed. No food was delivered or offered to resident #020.
- No staff entered resident #036's room, brought in or offered fluids or food to resident #036 who was in their bed.
- No staff entered resident #037's room, brought in or offered fluids or food who was in their bed.
Inspector #213 asked Staff Member #115 about providing only fluids to residents #019 and #020 and the Staff Member responded yes, that these residents did not come to the dining room and preferred to stay in bed so there was no choice. The Staff Member said that resident #019 was diabetic and because the resident received insulin in the morning, they were not comfortable with the resident having nothing, so fluids were provided.

In an interview with a Registered Dietitian (RD), Inspector #689 asked the RD if they would expect resident #008 to be offered food and fluids at all meal and snack times. The RD said that yes, they would expect this resident to be offered all meals and snacks along with fluids that are currently provided. The RD stated that short staffing may have impacted whether resident #008 and other residents had been offered meals and snacks in their rooms.

In an interview with the Director of Care (DOC), the point of care documentation of food and fluid intake for resident #008 was reviewed with the DOC and Inspector #689. The DOC said that the percentage of meal eaten for resident #008 was documentation related to oral intake only. The DOC followed up with Inspectors #689 and #213, and said that according to the nutrition recommendations and

dietitian notes, resident #008 received breakfast in the morning and specific fluids in the evening. Inspector #689 asked the DOC if resident #008 should be offered lunch and dinner meals in addition to a breakfast meal. The DOC responded with no, and stated that the resident's nutritional recommendations were discussed with the dietitian and that was what was decided.

The Meal Flow Sheets were reviewed by Inspector #689, and documentation of meal intake were noted as follows:
- A review of the clinical records for resident #008 showed no documentation for 49/90 (54 per cent) of meal times in the past 30 days. Meal frequency was indicated as breakfast, lunch and dinner.
- A review of the clinical records for resident #019 showed no documentation for 25/90 (28 per cent) of meal times in the past 30 days. Meal frequency was indicated as breakfast, lunch and dinner.
- A review of the clinical records for resident #020 showed no documentation for 22/90 (24 per cent) of meal times in the past 30 days. Meal frequency was indicated as breakfast, lunch and dinner.

A review of the home's policy entitled "Pleasurable Dining" with a revision date of March 2018, stated in the procedures that "any diet changes, room changes, special requests, need for tray service, or other changes to the resident's nutrition care are communicated to Nursing and Dietary staff as soon as possible to ensure accuracy of each resident's meal service."

A review of the home's policy entitled "Meal Service"; revision date January 2015, stated in the procedures that "residents are offered a minimum of three meals daily. If a resident chooses to miss breakfast, a larger, nutritious morning (AM) snack is provided (Nursing will inform the kitchen of the needs of the resident) and the Nutrition Care Plan is changed to reflect the resident's preferences" were expected when providing meals to residents.

A review of the home's policy entitled "Tray Service" with a revision date of January 2018, stated in the policy: "socialization at mealtimes in a designated dining area is always preferred and tray service is provided on a temporary basis only." The policy also stated in the procedures, criteria for resident's eligibility for tray service included:
- Illness/outbreak procedures;
- Totally bedridden;
- Palliative care;

- Behavioural issues awaiting appropriate assessment, and causing disruption in the dining room;
- Resident's request for a specific occasion, e.g. eating with visitors in an approved area within the Home.

In addition, the procedures noted that the "names of residents requiring tray service are forwarded to Dietary staff as soon as possible, at least ½ hours prior to the beginning of each meal unless regularly on the tray. Kitchen Requisition is completed and given to the kitchen by the Registered Staff."

The licensee failed to ensure that three meals per day were offered to residents #008, #019, #020, #036, #037, #039. [s. 71. (3) (a)]

Additional Required Actions:

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

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

WN #4: 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:
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 has failed to 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 was dealt with as follows: A documented record was kept in the home that included:
- The nature of each verbal or written complaint;
- The date the complaint was received;
- The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- The final resolution, if any;
- Every date on which any response was provided to the complainant and a description of the response; and
- Any response made in turn by the complainant.
The licensee has also failed to ensure that:
- The documented record was reviewed and analyzed for trends at least quarterly;
- The results of the review and analysis were taken into account in determining what improvements were required in the home; and
- A written record was kept of each review and of the improvements made in response.

The home's "Issues, Complaints and Concerns" policy, with a revision date of March 2016, was reviewed. The policy indicated:
"The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes:
a. The nature of each verbal or written complaint;
b. The date the complaint was received;
c. The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
d. The final resolution, if any;
e. Every date on which any response was provided to the complainant and a description of the response; and
f. Any response made in turn by the complainant.
The Administrator shall ensure that:
a. The documented record is reviewed and analyzed for trends at least quarterly;
b. The results of the review and analysis are taken into account in determining what improvements are required in the home; and
c. A written record is kept of each review and of the improvements made in

response."

In an interview with the Director of Care (DOC), Inspector #213 requested to review the home's complaint documentation. The DOC said that they did not know where this was and was looking into it. The Inspector asked if there was a form that was filled out for complaints, the DOC did not know; that the Executive Director took care of complaints. The Inspector asked if a family voiced a complaint at supper time to a staff member, how would that complaint and information get to the Executive Director to take care of, the DOC said this would happen verbally.

The Administrator provided a binder of critical incidents with no complaints in it on March 22, 2018. The Administrator also provided a folder with three complaints in it. The Administrator shared that these were complaints that they were currently working on. The Inspector asked for 2017 complaints again on March 28, 2018, and the Administrator provided a binder of complaints documented by the previous DOC, but this documentation ended in June 2017. There was no documentation of any complaints received by the home for the remainder of 2017 provided.

The three complaints dated 2018 were reviewed and included complaint forms titled "Craigwiel Gardens Complaints and Concerns Form":
- A complaint regarding resident #022 indicated that the resident had not received a bath or had bedding changed in weeks. In addition, that the resident had been found during the night still up in a chair and asking to go to bed and roommates had asked for assistance for two hours with no staff assistance provided. The complaint stated that this was unacceptable and was because there was no staff. The complaint further stated that during an outbreak, the resident had not received a bath, a bed bath or sponge bath or had bed linens changed for three weeks. Documentation included a phone call with the complainant. Documentation of the explanation offered by the home during this phone call included that "no baths are administered during an outbreak".
- Another complaint regarding resident #022 indicated that the resident had not received a bath and was supposed to have two baths per week. The outcome documented included the resident received a bath the following day. The subsequent day, it was not reported that baths were missed and the missed bath was brought to the attention of the Administrator at a family council meeting. The Administrator spoke to the DOC and requested a plan be put in place to address missed baths in time of short staffing situations. It also indicated "Requires Further Action". There was no documentation of any further follow up or response to complainant.

- A complaint regarding resident #001 indicated that the resident had not received care, i.e. shaving and bathing. Documentation in this complaint included immediate verbal follow up with the complainant.

In an interview with the family of an identified resident, the family member shared that they voiced a complaint, regarding specific care and treatments, to the DOC. They said that although the complaint was resolved, they did not receive any follow up from the home related to the resolution of the complaint and they did not hear back from the DOC.

In an interview with the DOC, the Inspector asked if they were aware of the complaint from the family of resident #005 regarding specific care and treatments. The DOC said that they were aware of the complaint. The Inspector asked of the complaint was documented, the DOC said that the complaint was documented in the resident's progress notes in Point Click Care (PCC), that the complaint was resolved and to their understanding, there was no further follow up with the complainant needed.

The progress notes for resident #005 were reviewed in PCC, and a progress note was found regarding the family's concern regarding a treatment not provided for resident #005. Three days later, the home received a physician's order for the treatment. On that date, the family of resident #005 called the home again to inquire if the treatment had been provided yet, and why it had not been done for several months previously. The family member spoke to a nurse who informed the family that they would be providing the treatment that day. The treatment was documented as completed on that date. There was no further documentation found regarding follow up with the complainant from the DOC, the home, or anyone else related to the resolution of their complaint, how it happened or what was done about it to prevent further issues.

The Inspector also asked the Administrator and the DOC for documentation of a review or analysis of complaints for 2017, for trends and improvements required. The home was unable to produce any documentation of any review or analysis of complaints received by the home in 2017 or 2018.

The licensee has failed to 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 was dealt with as follows: A documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was

received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, every date on which any response was provided to the complainant and a description of the response; or any response made in turn by the complainant. The licensee has also failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly, the results of the review and analysis were taken into account in determining what improvements were required in the home and a written record was kept of each review and of the improvements made in response. [s. 101. (1) 3.]

Additional Required Actions:

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

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 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:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that plans of care were based on, at a minimum, interdisciplinary assessment of residents' sleep patterns and preferences.

The Ministry of Health and Long-Term Care received six complaints over a ten week period, related to concerns regarding the home being short staffed.

In an interview with a Staff Member, the Staff Member said that the home is always short staffed for personal support workers (PSWs). The staff said that night staff have been expected to assist with morning care for residents when the day shift is short staffed and that night staff usually start morning care for residents between 0430 hours and 0500 hours depending on how many residents they got up.

In an interview with another Staff Member on an identified date, when asked if nights got residents up that morning, they said yes, there were six residents up in the middle wing alone, they were washed, dressed and up in their chairs at 0600 hours that morning when day staff arrived. In an interview with another Staff Member on that date, they said that there were five PSWs working days that day.

The "Nursing Staffing" plan was reviewed and found that the plan included nine PSWs for day shift including two PSWs assigned to a bath shift. Day shift was to start at 0600 hours and end at 1400 hours. The "Staffing Contingency Plan document provided by the Director of Care (DOC) was reviewed and indicated for "4 PSW Short: 5 PSW: Night staff to complete am care and dress a minimum of 9 residents".

In an interview with the DOC, the Inspector asked about the contingency plan where it says for five PSWs on; four PSWs short, that night staff are to get nine residents washed and dressed, the DOC said yes. The Inspector asked what time they start getting residents up on nights, the DOC said about 0515 hours. The Inspector asked if the night shift was finished at 0600 hours, the DOC said yes. The Inspector asked how they got nine residents washed and dressed in less than 45 minutes. The DOC said that there were four staff on night shift and that they don't necessarily get residents up in their chairs, just washed and dressed in their beds.

In an interview with a Staff Member on another date, they said that there were five PSWs working that day with one of the five on modified duties, unable to complete all aspects of resident care. The Staff Member said that night staff got several residents washed and dressed that morning, they had a list on paper of which residents were washed and dressed and it was also documented in Point Click Care (PCC) on the Dashboard.

On an identified date, the Point of Care "Shift Dashboard" in PCC was reviewed, specifically, the "Alerts Triggered in the last 24 hours". The documentation showed the following:

05:55 Resident #023 washed and dressed by night staff
05:54 Resident #021 washed and dressed by night staff
05:54 Resident #031 washed and dressed by night staff
05:54 Resident #027 washed and dressed by night staff
05:54 Resident #029 washed and dressed by night staff
05:53 Resident #015 washed and dressed by night staff
05:53 Resident #008 washed and dressed by night staff
05:42 Resident #012 washed and dressed by night staff
05:41 Resident #032 washed and dressed by night staff
05:41 Resident #033 washed and dressed by night staff
05:40 Resident #034 washed and dressed by night staff
05:39 Resident #030 washed and dressed by night staff
05:39 Resident #014 washed and dressed by night staff
05:38 Resident #035 washed and dressed by night staff
05:37 Resident #009 washed and dressed by night staff

Fifteen residents were documented as washed and dressed by night staff on that day, with the documentation completed between the hours of 0537 hours and 0555 hours.

The plans of care for residents #008, #023, #029, #030 and #031 were reviewed and no reference to sleep patterns or preferences was found for any of these five residents who had been washed and dressed prior to 0537 hours on that date.

In an interview with the DOC, Inspector #213 reviewed the care plans for residents #008, #023, #029, #030 and #031 and the DOC agreed that sleep patterns and/or preferences were not included in the care plans for these residents. The Inspector asked the DOC if there was anywhere else that sleep patterns and/or preference might be found for these residents and the DOC said no, that would and should be in the care plan in PCC for all residents.

The licensee has failed to ensure that plans of care were based on, at a minimum, interdisciplinary assessment of residents' sleep patterns and preferences for residents #008, #023, #029, #030 and #031, who were all washed and dressed before 0537 hours on an identified date. [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 plans of care are based on, at a minimum, interdisciplinary assessment of residents' sleep patterns and preferences, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 231. Resident records
Every licensee of a long-term care home shall ensure that,
(a) a written record is created and maintained for each resident of the home; and
(b) the resident's written record is kept up to date at all times. O. Reg. 79/10, s. 231.

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's written record was kept up to date at all times.

The Ministry of Health and Long-Term Care received a complaint, which included a concern related to care concerns for resident #001.

In an interview with the family member of resident #001, the family member shared that the resident had a procedure on an identified date and time. The family member stated that when they spoke to the home staff about the resident's condition, the evening staff were not aware that the resident had a procedure that day and advised them that there was no documentation related to the procedure.

Record review of the home's policy titled "Medical Records Documentation", with a revision date of March 2016 was completed. The policy stated under "Areas Which Should be Charted": "Incidents injury and assessments should be charted as soon

after the occurrence as possible to ensure accuracy" and "describe the exact time, effect and reaction of the resident to treatment, and/or therapy rendered".

Progress notes in Point Click Care (PCC) for resident #001 were reviewed. There was no documentation found on the identified date related to an assessment of the resident or a procedure.

A progress note was created the following day after the procedure that stated: the day previous, late entry – resident had a procedure and actions taken related to the procedure.

The care plan, assessments, treatment administration records, medication administration records and physician's orders were reviewed for resident #001 and no information was found on the identified date related to a procedure or change in condition.

In an interview with the Director of Care (DOC), the DOC reviewed the progress notes in PCC for resident #001 with the Inspector and agreed that there was no documentation of a procedure or assessment of the resident on the identified date, when the procedure occurred. The DOC said that the staff did not document anything about the procedure or assessment of the resident until the following day. The DOC said that the assessment and appropriate actions were taken, but that it was not documented when it occurred and it should have been.

The licensee has failed to ensure that the resident's written record was kept up to date, when staff completed documentation related to assessment of a resident the day after it was completed for resident #001. [s. 231. (b)]

Issued on this 24 day of May 2018 (A1)

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

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Long-Term Care Homes Division
Long-Term Care Inspections Branch
Division des foyers de soins de longue durée
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Name of Inspector (ID #) / Nom de l'inspecteur (No) : Amended by RHONDA KUKOLY (213) - (A1)

Inspection No. / No de l'inspection : 2018_605213_0005 (A1)

Appeal/Dir# / Appel/Dir#:

Log No. / No de registre : 027582-17, 000055-18, 000598-18, 000805-18, 001888-18, 002773-18, 005174-18 (A1)

Type of Inspection / Genre d'inspection: Complaint

Report Date(s) / Date(s) du Rapport : May 24, 2018;(A1)

Licensee / Titulaire de permis :
Craigwiel Gardens
221 Main Street, R. R. #1, AILSA CRAIG, ON, N0M-1A0

LTC Home / Foyer de SLD :
Craigholme
221 Main Street, R.R. #1, AILSA CRAIG, ON, N0M-1A0

Name of Administrator / Nom de l'administratrice ou de l'administrateur : Gemma Nott

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

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

Order / Ordre :

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

Specifically, the licensee shall ensure the following:
a) Ensure resident #006, and any other resident, when indicated in the plan of care, have the number of side rails in use as specified in the plan of care.
b) Ensure that all nursing staff receive training related to the use of bed rails as per residents' plans of care. Attendance records for this training are to be maintained.
c) The home will develop and implement an auditing process to ensure that resident #006 specifically, and any resident who uses bed rails, have the number of side rails in use as specified in the plan of care. Records for these audits are to be maintained.

Grounds / Motifs :

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

The Ministry of Health and Long-Term Care received a complaint, which included a concern related to falls prevention.

The following observations were completed during the inspection:

- On an identified date and time, resident #006 was walking in the hallway. In the resident's room, there were two side rails in use. There was a sign above the bed that indicated days: one rail, nights: one rail, right side.
- On another identified date and time, resident #006 was observed lying in bed with two side rails in use. There was a sign above the bed that indicated days: one rail, nights: one rail, right side.
- On another identified date and time, resident #006 was walking in the hallway. In the resident's room, there were two side rails in use. There was a sign above the bed that indicated days: one rail, nights: one rail, right side.

The care plan in Point Click Care (PCC) for resident #006 was reviewed and showed:
- Bed Safety: 1 bed rail
- Number side rails as per assessment/resident preference refer to over bed logo

Assessments in PCC for resident #006 were reviewed. The last "Bed Rail Assessment" indicated: One side rail for bed mobility and positioning assistance.

The home's policy "Bedrails", with a revision date of March 2016, was reviewed. The policy indicated: "Use of bed rails should be based on residents' assessed medical needs and should be documented clearly and approved by the interdisciplinary team".

In an interview with the Assistant Director of Care (ADOC) and Inspector #689, the ADOC agreed that two side rails were in use and that the sign above the bed indicated one side rail on the right side to be used days and nights. They said they were not sure whether the bed rails that were in use were correct, or if the signage was correct.

The licensee has failed to ensure that the care set out in the plan of care, related to the use of side rails for resident #006, was provided to the resident as specified in the plan.

The severity of this issue was determined to be a level 2 as there was a potential for actual risk/harm to the residents and the area of non-compliance is a Key Risk Indicator. The scope of the issue was a level 1 as it related to one of three residents reviewed. The home had a level 4 history of on-going non-compliance with this section of the Act that included: Voluntary plans of correction (VPC) issued:

- January 11, 2018 (2017_533115_0005)
- July 7, 2017 (2017_660218_0003)
- May 17, 2017 (2017_605213_0005), specifically related to the use of bed rails
- January 23, 2017 (2017_263524_0003), specifically related to the use of bed rails

(213)

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

Jul 06, 2018(A1)

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. 31. (3) The staffing plan must,

(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs and that meets the requirements set out in the Act and this Regulation;

(b) set out the organization and scheduling of staff shifts;

(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident;

(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff, including the staff who must provide the nursing coverage required under subsection 8 (3) of the Act, cannot come to work; and

(e) be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 31 (3).

Order / Ordre :

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

Specifically, the licensee shall ensure the following:
a) Ensure that residents #001, #004, #005, #006, #007 and #009, and all other residents, are bathed at a minimum twice a week by the method of their choice and bathing is documented.
b) Ensure that the sleep patterns and preferences for residents #008, #023, #029, #030 and #031, and all other residents, are adhered to as per the residents' individual plans of care.
c) Ensure that residents #004, #005, #011, #012, #025, #026, #027, #028, and all other residents, receive fingernail care, including the cutting of fingernails, and nail care is documented.
d) Ensure that resident #012, and all other residents, receive individualized personal care, including hygiene care and grooming on a daily basis, and personal care is documented.
e) Ensure that resident #006 and all other residents are dressed appropriately, suitable to the time of day and in keeping their preferences, in their own clean clothing and in appropriate clean footwear, and dressing care is documented.
f) Ensure that residents #016 and #017, and all other residents who require assistance with eating or drinking are not served meals until assistance is available to provide the assistance required by the resident.
g) Ensure that that staff do not provide feeding assistance simultaneously to more than two residents who need total assistance with eating or drinking.
h) Develop and implement an auditing process to ensure that all residents' sleep and rest routines are adhered to, that all residents receive two baths per week by the method of their choice, finger nail care, hygiene and grooming on a daily basis and assistance with dressing suitable to the time of day and in keeping with their preferences; as specified the residents' individual plans of care. Records for these audits are to be maintained.
i) Evaluate and revise the home's "Staffing and Recruitment Crisis Planning" document including the staffing plan and the contingency plan on a monthly basis. The revised plans will be implemented and include issues, short and long term goals, action items, responsible persons, target dates, evaluation and resolved dates. This monthly review and revision will continue until the home is consistently, fully staffed, according to their staffing plan. The evaluation and revision and the dates completed will be documented.

Grounds / Motifs :

1. The licensee has failed to ensure that the written staffing plan (including the back-up plan for nursing and personal care staffing that addresses situations when staff, cannot come to work); for the programs including Personal Care, Bathing, Foot Care and Nail Care, Dress, Bedtime and Rest Routines; provided for a staffing mix that was consistent with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulations.

The Ministry of Health and Long-Term Care received six complaints during a ten week period, related to concerns about the home being short staffed, including multiple care concerns.

A review of the "Staffing Planning" policy with a revised date of April 2017 was completed. The daily pattern unit included:
Days:
Registered Nurse (RN) – 1
Registered Practical Nurse (RPN) – 3
Personal Support Worker (PSW) – 9

Evenings:
Registered Nurse – 1
Registered Practical Nurse – 3
Personal Support Worker - 9

Nights:
Registered Nurse – 1
Registered Practical Nurse – 0
Personal Support Worker – 3

The home's staffing schedules were reviewed for a five week period of time. The number of day shifts of PSWs capable of fulfilling full resident care needs over a 37 day period were as follows:
- 3 ½ worked shifts out of 9 planned shifts on 1 day.
- 4 worked shifts out of 9 planned shifts on 12 days.
- 5 worked shifts out of 9 planned shifts on 6 days.
- 5 ½ worked shifts out of 9 planned shifts on 1 day.
- 6 worked shifts out of 9 planned shifts on 13 days.

- 6 ½ worked shifts out of 9 planned shifts on 1 day.
- 7 worked shifts out of 9 planned shifts on 3 days.

The "Staffing Contingency Plan" was reviewed and indicated direction and routines as follows:
1 PSW short: 8 PSW
2 PSW short: 7 PSW
3 PSW short: 6 PSW
4 PSW short: 5 PSW
5 PSW short: 4 PSW

For 3 PSW Short: 6 PSW
- Follow 6 Aide assignment in Point of Care (POC) – each staff assigned 14 residents
- Night staff to complete am care and dress a minimum of 6 residents (list at desk of residents who will have minimum impact of being woken early)
- Registered staff to assist with care and transfers as able. RN to assist with care before breakfast if full RPN staff.
- Consider offering bed baths as time allows
- Ask other departments to assist with portering and feeding in dining room

4 PSW Short: 5 PSW
- Follow 5 Aide assignment in POC – Top and Bottom pick up from Middle assignment
- Night staff to complete am care and dress a minimum of 9 residents (list at desk of resident who will have minimum impact of being woken early)
- RN to assist with care before breakfast if full RPN staff
- Ask other departments to assist with portering and feeding in dining room
- Paper Food and Fluid record to be used – any staff can assist in completing and registered staff will enter into POC
- Dietary staff to serve in dining room (evening shift)

For 5 PSW short: 4 PSW
- RN to assign one RPN to the floor and 2 RPN to complete med pass for home
- RN and RPN to assist with resident care on the unit
- "pyjama day" if residents agree, may go to dining room for breakfast in housecoat or if evening shift, change residents as the y agree into pyjamas after lunch
- if morning shift short, night staff to complete am care and dress a minimum of 12

residents
- ask other department to assist with portering residents and feeding in dining room
- one dietary staff and one PSW to complete snack cart
- dietary staff to serve in dining room (evening shift)

A review of "Craigwiel Gardens Staffing Vacancies", provided by the Director of Care #100 was completed and indicated:
Part time RN – 3 Positions
Part time RPN – 1 Position
Temporary Part Time RPN – 1 Position
Temporary Full Time PSW – 3 Positions
Full Time PSW – 1 Position
Scheduled Part Time PSW – 1 Position
Part Time PSW – 5 Positions
Temporary Part Time PSW – 3 Position
Weekend Worker PSW – 1 Position

A record review of the documentation of complaints received by the home was completed. The three complaints were reviewed and included:
- On an identified date, a complaint regarding resident #022 indicating that the resident had not received a bath or had bedding changed in weeks. The resident had been found during the night still to be up in their chair and asking to go to bed. In addition, their roommates had asked, for up to two hours, for assistance, with no staff assistance provided. The complaint stated that this was unacceptable and was because there was no staff. The complaint further stated that during an outbreak, resident #022 had not received a bath, a bed bath or sponge bath, or had bed linens changed for three weeks. Documentation included a phone call with the complainant on an identified date. Documentation of the investigation included: "While it is true that we have not had the same complement of staff on the floor as usual due to staffing challenges, we are faced with barriers in our efforts. We have been in two outbreaks (one for respiratory lasting 30 days) and one for Influenza A lasting two weeks. During any outbreak, we do not put residents in the tub for infection control purposes. While it is possible that they may have not had a bath, it is also possible that they had bed baths while in outbreak."
- On another identified date, a complaint regarding resident #022 indicated that the resident had not received a bath and was supposed to have two baths per week. The outcome documented included that the resident received a bath the following day. The subsequent day, it was not reported that baths were missed. Missed baths were

brought to the attention of the Administrator at a family council meeting. The Administrator spoke to the Director of Care (DOC) and requested a plan be put in place to address missed baths in time of short staffing situations.
- On an identified date, a complaint regarding resident #001 indicated that the resident had not received care, i.e. shaving and bathing.

A review of "Residents' Council Meeting Minutes" was completed. One identified meeting had eight residents documented in attendance and the Residents' Council Assistant was documented as being the Director of Care and the Administrative Assistant. Under "Home Areas Updates and Discussion", for Nursing and Personal Care, the minutes stated: "Very happy with the staff, staff are very good to them. Have noticed that sometimes the beds are not getting made, they know that the staffing level is low. We are doing everything we can to recruit new staff, hope to get some new people in soon. Have been interviewing and advertising."

The following memos were noted in the staff communication book:
- We are continuing to have challenges with staffing. Ongoing recruitment is happening but unfortunately takes time. I have said before, it is important to be sure we get the right people in to work here and not just anyone. As recruitment goes on, we have a duty to continue to provide care for residents. It is not acceptable to not do any baths because we do not have full staff. When we are working short, residents can be offered a bed bath or shower instead of a tub bath. Also, when working short staffed in the evening, we still need to work with the dietary staff to ensure that the resident meals are served. Saying we will not serve soup is not appropriate for the residents and a waste of food. When working short, it is the responsibility of the RN to coordinate with all staff on to ensure that resident care is completed. It is expected that RN and RPN staff will assist with personal care as needed.
- If we are doing a bed bath for a resident and we are counting it as their bath for the day, we are able to use the bath in a bag and the hair wash caps. Please be sure that it gets documented in POC as their bath.
- Because of short staffing, bowel movements are not always getting charted. Please ask your PSW's before giving laxatives.
- To the night staff from an identified date. The day staff would like to thank you for all of your awesome help for the residents Saturday morning. It was truly appreciated!
- Our ongoing staffing crisis is a challenge to everyone. It is times like this that it is more important than ever that we work together to provide the best possible care for all of our residents. This means registered staff stopping during their med pass to assist with a transfer.

On an identified date, the Point of Care "Shift Dashboard" in Point Click Care (PCC) was reviewed, specifically, the "Alerts Triggered in the last 24 hours". The documentation showed the following:
05:55 Resident #023 washed and dressed by night staff
05:54 Resident #021 washed and dressed by night staff
05:54 Resident #031 washed and dressed by night staff
05:54 Resident #027 washed and dressed by night staff
05:54 Resident #029 washed and dressed by night staff
05:53 Resident #015 washed and dressed by night staff
05:53 Resident #008 washed and dressed by night staff
05:42 Resident #012 washed and dressed by night staff
05:41 Resident #032 washed and dressed by night staff
05:41 Resident #033 washed and dressed by night staff
05:40 Resident #034 washed and dressed by night staff
05:39 Resident #030 washed and dressed by night staff
05:39 Resident #014 washed and dressed by night staff
05:38 Resident #035 washed and dressed by night staff
05:37 Resident #009 washed and dressed by night staff
Fifteen residents were documented as washed and dressed by night staff on the identified date, with the documentation completed between 0537 hours and 0555 hours.

The home's bath schedules and the Point of Care documentation for bathing completed for a four week period of time, were reviewed in PCC by Inspector #689. Given the understanding that the following residents requested to have two baths per week, documentation of resident baths over the four week period was noted as follows:
- Resident #001: 3 out of 8 opportunities (38 per cent), there was no bath documented.
- Resident #004: 6 out of 8 opportunities (75 per cent), there was no bath documented.
- Resident #005: 4 out of 8 opportunities (50 per cent), there was no bath documented.
- Resident #006: 2 out of 8 opportunities (25 per cent), there was no bath documented.
- Resident #007: 3 out of 8 opportunities (38 per cent), there was no bath documented.

- Resident #009: 4 out of 8 opportunities (50 per cent), there was no bath documented.

A record review of POC documentation in PCC was completed. Documentation related to recording of resident bowel movements was noted as follows:
- Resident #001: 17 out of 30 dates (56 per cent) did not have any documentation of bowel movements on every shift.
- Resident #005: 14 out of 30 dates (46 per cent) did not have any documentation of bowel movements on every shift.
- Resident #008: 23 out of 30 dates (76 per cent) did not have any documentation of bowel movements on every shift.

A record review of POC documentation in PCC was completed. Documentation related to recording of resident intake of meals was noted as follows:
- Resident #008: 49 out of 90 of meal times (54 per cent) did not have any documentation of intake.
- Resident #019: 25 out of 90 meal times (28 per cent) did not have any documentation of intake.
- Resident #020: 22 out of 90 meal times (24 per cent) did not have any documentation of intake.

Observations of the lunch meal service by Inspector #689 on an identified date, identified one staff member provided feeding assistance to four residents in the dining area at the same time.

Observations of the lunch meal service by Inspector #689 on an identified date, identified resident #017 being served their meal with no staff present. The resident was not able to eat unassisted. Eight minutes later, the resident was assisted with feeding the meal that had been served.

Observations on an identified date, between 0845 hours and 0950 hours identified the following:
- The Director of Care (DOC) and the Administrator were observed helping feed and assist in the dining room
- The Chaplain, activation staff and other plain clothes staff were observed assisting with portering residents to and from the dining room and with feeding residents in the dining room
- Housekeeping staff and maintenance staff were observed assisting with portering

residents to the dining room
- PSW staff were observed feeding in the dining room, as well as, assisting residents with personal care in rooms and portering them to the dining room. At 0850 hours, a staff member brought a resident into the dining room and said to another staff member you need to get [a resident] up, they're not up yet, the Staff Member responded they're not up? Okay. The staff member left the dining room.

Observations of the morning meal service on another identified date, at 0904 hours, identified one staff member going back and forth between two tables in the dining area to provide assistance with feeding four residents at the same time.

Observations of the morning meal service on another identified date, at 0846 hours, identified one staff member providing assistance with feeding three residents at one table in the dining area at the same time.

Observations of the morning meal service on an identified date, at 0853 hours, identified resident #016 was served oatmeal, eggs and toast with no staff available to assist with feeding. At 0859 hours, the resident was asked by the Administrator if they needed help. The resident was then removed from the dining area by another staff member and at 0904, the resident was brought back into the dining area and the DOC assisted the resident with feeding the meal that had been served at 0853 hours.

Observations on another identified date, at 0850 hours identified the following:
- During the breakfast meal, the Assistant Director of Care (ADOC) and the Administrator were observed feeding and assisting in the dining room
- Housekeeping staff and maintenance staff were observed assisting with portering residents to the dining room
- PSW staff were observed feeding in the dining room, as well as still, assisting residents with personal care in rooms and portering them to the dining room

Observations on an identified date between 0935 hours and 1035 hours identified the following:
- 0935 hours: Resident #006 was walking from the direction of the dining room to their room down the hall and was wearing pyjamas, a housecoat/robe and slippers.
- 0937 hours: Resident #006 was observed in bed wearing pyjamas and a robe, lying under the covers.
- 0940 hours: Inspector #213 asked Staff Member #106 why resident #006 was still

wearing night clothes and a robe. The Staff Member said that it was because the staff didn't have time to provide care for the resident yet that morning, so they put a robe on so they could go for breakfast. The Inspector asked if the resident was scheduled for a bath that day, and the Staff Member said no.
- 1035 hours: Resident #006 was observed lying in bed still wearing pyjamas and robe on, under the covers.

Observations conducted on an identified date, between 1446 hours and 1519 hours with Inspector #213 and #689 identified the following:
-Resident #012 was in a lounge with the TV on, sitting in a wheelchair. The resident's finger nails were long and uncut, they were unshaven with several days' hair growth, and their shirt was soiled with a yellowish substance, a large area approximately the size of a grapefruit.
-Resident #025 was in their room. The resident's fingernails were clean, but uncut.
-Resident #005 was in their room in bed. The resident's fingernails were clean, but uncut.
-Resident #026 was in their room sitting on the bed. The resident's fingernails were clean, but long and uncut.
-Resident #027 was in the lounge near the nursing station sitting in a manual wheelchair. The resident's hair was unkempt and their nails were long, chipped and broken.
-Resident #028 was in the hallway sitting in a wheeled chair. The resident's nails were soiled under the nail, long and uncut.
-Resident #004 was sitting in their room in a wheeled chair. The resident's hair was messy and unkempt, and their nails were long and uncut.
-Resident #011 was in their room. The resident's nails were long and chipped, but painted.

Observations conducted three days later, at 1415 hours by Inspector #213 identified the following:
-Resident # 012 was in their room in bed sleeping. The resident's fingernails were clean, but still long and uncut.

Observations conducted the following day, between 0950 hours and 1505 hours by Inspector #213 identified the following:
-Resident #025 was in a hallway in a wheelchair self-propelling to their room after breakfast. The resident's fingernails were clean, but still long and uncut.
-Resident #012 was in a lounge with a TV in the lower unit. The resident was

unshaven, had a shirt soiled with food, and had fingernails with dirt under the nail and still uncut.
-Resident #026 was in their room sitting in a lazy boy chair with the TV on and eyes closed. The resident's fingernails were still long, right thumb nail was specifically long, broken and chipped.
-Resident #028 was in their room sleeping. The resident's fingernails were long, had dirt underneath and still uncut.
-Resident #004 was in their room sitting in a wheeled chair. The resident's hair was messy and unkempt, fingernails were still long and uncut.

In an interview with a Staff Member, the Staff Member said that the home is always short staffed for personal support workers (PSWs). The staff said that night staff had been expected to assist with resident morning care when the morning shift was short staffed. They said that the night staff usually started morning care for residents between 0430 hours and 0500 hours, depending on how many residents they got up. When asked if baths were getting completed, the Staff Member answered no, baths were not getting completed. The Staff Member said that if a bath or a shower was not completed, the staff were told to document that the resident had a bed bath, even if the resident just had regular morning care. When asked if staff were always getting documentation completed, the Staff Member said no. When asked how long the staffing had been a problem, they said since before Christmas, to date. They said it's not fair for the residents, they're not getting proper care. When asked if there was enough staff to feed the residents, they said no, they're getting cold meals. When asked how many residents the staff were providing feeding assistance to, they said there's one staff for four residents requiring feeding assistance. The Staff Member said that they're late getting to the dining room for breakfast and lunch because they're still getting people up.

In an interview with another Staff Member, the Inspector asked the Staff Member if they were short staffed that day, and the staff answered yes. The Inspector asked how many staff they had that day, and they said six in total, five on the floor with one staff assigned to complete baths. The Inspector asked if the home was having issues with short staffing, and the staff answered yes. When asked how long this had been a problem, the staff responded since before Christmas. The Staff Member shared that the lowest staffing they had experienced was three PSWs on the floor on days, and when that happened, they would pull a registered practical nurse (RPN) to work on the floor and potentially call in a registered nurse to cover the RPN shift. The Staff Member said that the DOC and Administrator have both helped with portering

residents to and from the dining room and assisting with feeding. When asked if baths were getting done, the Staff Member said no, that they have been trying to get a bed bath in, but rarely, and that it had been affecting nail care as well. When asked if other resident care has been affected, the Staff Member answered, in general hair washing and nails. The Inspector stated that the chaplain, activity staff and managers were observed helping with breakfast service that day and asked the Staff Member if that was usual. The Staff Member said the chaplain portered residents to and from the dining room, and the activity staff helped with feeding. They said that occasionally the Administrator assisted as well, but not every day. When asked what happened on the weekend when all of the support staff were not in the home, the Staff Member said that they relied on dietary to help porter. They said that housekeeping staff would also help when necessary. The Inspector asked if staff have needed to feed more than two residents at a time, and they said yes. When asked if all documentation had been completed, they answered no, not always. The Inspector asked the Staff Member if they remembered a day when they did not work short staffed. The Staff Member answered no.

In an interview with another Staff Member, when asked if the nursing shortages were affecting dietary service, they answered yes. When asked how long this had been an issue, they said for a long time and had been short for months, since Christmas time. The Staff Member said that they and the dietary staff were helping with portering residents to and from the dining room and feeding residents. The Staff Member said that it did affect the dietary department with the residents getting into the dining room late, sometimes on weekends not until 0950 hours and breakfast was supposed to start around 0800 hours. They said that when breakfast was late, everything else for the rest of the day was late, including the morning snack cart.

In an interview with another Staff Member, when asked if the nursing staffing shortages were affecting dietary service, they said nursing staffing affected everyone. They said dietary aides and cooks assisted with porting residents to the dining room for breakfast. The Staff Member said that one dietary staff would collect and help feed the residents, but they couldn't help them out of bed. When asked if they have had training on how to properly feed residents, the Staff Member answered no. The Staff Member said that because residents were getting to the dining room later, the meals were starting later. They said that this made it hard for dietary staff to clear tables, because they couldn't move carts around to clear as people were still eating. The Staff Member further said that they couldn't get all the dishes done, which put the routine behind with snack service.

In an interview with another Staff Member, the Inspector asked if the home was having issues with short staffing and they answered yes, particularly PSWs. When asked how this was affecting resident care, they answered that it was affecting care; baths had not been getting done twice a week. The Staff Member said that staff had to pick and choose what care was done, because there were not enough bodies. When asked what care besides baths had been affected, the Staff Member said residents were leaving the dining room without having their mouth washed, mouth care was not done, toileting schedules were not followed, residents were staying in a wet brief longer than they would have, and nail care was not getting done because nails get done in the bath. The Inspector asked if staff were completing all documentation as required and resulting impacts. The Staff Member shared that residents had potentially received a laxative when it wasn't necessary, because bowel movements were not documented. They said low fluid referrals had also been made because fluids weren't documented.

In an interview with a non-nursing Staff Member, the Staff Member stated that it was a requirement of their job to feed residents one meal a day during their shift. The Inspector asked if they had received training related to feeding residents, and they answered no. They said that they helped to feed three of the four residents at one particular table in the dining area, but the fourth resident was needing more assistance and asked for help. The Staff Member stated they would go around the table to all four residents the best they could using a wheeled stool.

In an interview with another Staff Member, when asked if nights got residents up that morning, they answered yes. They said there were six residents up in the middle wing alone that day and they were washed, dressed, and up in their chairs at 0600 hours that morning when day staff arrived.

In an interview with another Staff Member on that date, they said that there were five PSWs working days that day.

In an interview with the DOC, the Inspector asked if the home had staffing issues recently, the DOC said yes, serious staffing issues. The DOC said there are issues at all levels, but they were really short on PSWs.

In an interview with the DOC on another date, the Inspector asked about the contingency plan where it stated: for five PSWs on; four PSWs short, that night staff

are to get nine residents washed and dressed, the DOC answered yes. The Inspector asked what time they start getting residents up on nights, and the DOC said about 0515 hours. The Inspector asked if the night shift is done at 0600 hours, the DOC said yes. The Inspector asked how the staff could get nine residents washed and dressed in less than 45 minutes. The DOC said that there are four staff on night shift and that they didn't necessarily get residents up in their chairs, just washed and dressed in their beds.

In an interview with the DOC on another date, the Inspector asked if bed baths were being counted as tub baths. The DOC said staff could give a bed bath, tub bath, or shower, depending on the resident's plan of care. The DOC said the problem with bed baths was that resident's hair didn't get clean, but the home got the 'bath in a bag' with the 'hair caps' to get the residents' hair clean. The DOC answered no, that a bed bath substituted for a tub bath was not the residents' method of choice for bathing, when asked by the Inspector.

In an interview with another Staff Member on another date, they said that there were five PSWs working that day with one of the five on modified duties, unable to complete all aspects of resident care. The Staff Member said that night staff got several residents washed and dressed that morning, and they had a list on paper of which residents were washed and dressed and it was also documented in Point Click Care (PCC) on the Dashboard.

In an interview with resident #011 on an identified date, Inspector #689 noted that the resident's nails were long and chipped, but painted. The Inspector verbally noted their painted nails and the resident said that their family had painted them. When asked if the staff cut their nails, the resident said, oh no, they didn't do that. The resident then said "they finally washed my hair today". Inspector #689 asked when was the last time they had their hair washed, and they said they didn't know, last week some time.

In an interview with a family member, the family member shared that their loved one in the home had missed three baths on specific dates, and then said that the resident had a make-up bath for one of the baths on an identified date.

In an interview by Inspector #689 with resident #022 on an identified date and time, when asked if they had any concerns with bathing, the resident said their family member and them had concerns with not getting a bath. The resident said that their

first bath of the week would be missed and wouldn't get another bath until the end of the week. The resident was not able to remember when their bath was missed and said that their family advised them to write it down.

A review of the home's policy entitled "Medical Records Documentation" with a revision date of March 2016, stated Charting Procedure: "The following information shall be documented in the electronic medical record: Daily care documentation via Point of Care System".

A review of the home's policy entitled "Pleasurable Dining" with a revision date of March 2018 stated under procedures the following:
- No resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance by the resident.
- Staff assist no more than two residents at time with eating and/or drinking

A review of the home's policy entitled "Nail Care", with a revision date of March 2016, stated the following:
- All residents will have their fingernails cleaned and trimmed on bath day.
- Encourage resident to be as independent as possible and provide assistance as necessary.

A review of the home's policy entitled "Bathing", with a revision date of March 2016, stated the following:
- All residents will be bathed twice per week, by method of their choice on a regularly scheduled day.

The "Staffing Plan Craigwiel Gardens 2018 - 2019" with an evaluation date of March 2018, and a revised date of March 22, 2018, was reviewed after the Administrator provided this document indicating that this was the home's staffing plan evaluation. The evaluation included "goals to achieve the purpose", "indicators to monitor", "results against targets", and "new strategies to improve results". Under "results against targets" there were "time period (e.g. monthly, quarterly)" and "baseline", "target", and "result" fields. The entire "results against targets" field was blank for all goals with no baseline, targets to achieve, or target dates identified. No persons were identified as responsible for indicators or new strategies.

The licensee has failed to ensure that the written staffing plan and the back-up plan for nursing and personal care staffing provided for a staffing mix that was consistent

with residents' assessed care and safety needs and that met the requirements set out in the Act and the Regulations. The home was operating on their back-up plan every day, over a five week period of time. There were two to six less personal support workers working day shift than the staffing plan allotted. During this time, residents did not receive two baths per week, daily grooming and hygiene, nail care, assistance required for feeding, staff were feeding more than two residents at a time, documentation was not completed and numerous residents were being washed and dressed before 0530 hours.

The severity of this issue was determined to be a level 2 as there was a potential for risk/harm. The scope of the issue was a level 3 as it related to all residents in the home. Compliance history was a level 2 as there was unrelated non-compliance in this subsection of the legislation.
(213)

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

Jul 06, 2018(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. 71. (3) The licensee shall ensure that each resident is offered a minimum of,
(a) three meals daily;
(b) a between-meal beverage in the morning and afternoon and a beverage in the evening after dinner; and
(c) a snack in the afternoon and evening. O. Reg. 79/10, s. 71 (3).

Order / Ordre :

The licensee must be compliant with r. 71(3)(a) of the LTCHA.

Specifically, the licensee shall ensure the following:
a) Ensure residents #008, #019, #020, #036, #037, #039, and all other residents, are offered three meals per day (breakfast, lunch and dinner), including when residents do not go to the dining room.
b) Ensure documentation of meal intake and meal offerings is completed for residents #008, #019, #020, #036, #037, #039, and all other residents.
c) Review and revise the "Tray Service" policy including:
i) the policy statement
ii) the procedure statement for criteria for resident's eligibility for tray service
iii) the procedure statement related to the process for communicating tray service to kitchen staff to include specific directions for who, what, where, when and how.
d) Ensure that all nursing and dietary staff receive training related to the home's tray service policy, including individual roles and responsibilities. Attendance records for this training are to be maintained.
e) The home will develop and implement an auditing process to ensure that residents #008, #019, #020, #036, #037, #039 specifically, and all other residents, are offered three meals per day and documentation is completed. Records for these audits are to be maintained.

Grounds / Motifs :

1. The licensee has failed to ensure that residents were offered a minimum of three meals daily.

The Ministry of Health and Long-Term Care received a complaint, which included a concern related to nutrition and hydration for a specified resident.

Observations on an identified date, between 0930 hours and 1000 hours:
- Resident #019 was in their room in bed during the breakfast meal.
- Resident #039 was in their room in bed during the breakfast meal.
- Resident #008 was in their room in bed during the breakfast meal.
Resident #008 was not offered breakfast. Inspector #689 asked resident #008 if they had breakfast and the resident shook their head no. The Inspector asked if they were offered breakfast and the resident shook their head no. The Inspector asked if they wanted to have something for breakfast and the resident nodded yes. Staff Member #106 indicated that this resident sometimes got breakfast and was not sure why dietary staff did not make a food tray. Inspector #689 informed the Staff Member that resident #008 said they wanted breakfast.

The plan of care for resident #008 was reviewed and indicated a regular diet and a therapeutic diet.

In an interview with a non-nursing Staff Member, the Staff Member said that kitchen staff were not aware that resident #008 required tray service for meals. The staff further stated that they did not know if resident #008 had any meals or meal trays offered for a three month period of time. The Staff Member stated that meal offerings were falling through the cracks and said that one day, they noted that resident #038 was not in the dining room for breakfast and lunch, so the non-nursing staff themself sought out the resident and made sure the resident got supper that day. When asked what the process was for residents receiving meals who were not in the dining room, they said that the home's policy stated that the nurse was to send a requisition to the kitchen staff requesting tray service for residents not able to go to the dining room.

In an interview, a Staff Member indicated that nursing staff were to send a requisition to the kitchen for residents that did not go to the dining room for a meal. The Staff Member identified that resident #015 was the only resident who regularly received set meal tray service. When asked about meals for resident #008, they said the kitchen did not receive a meal tray requisition for this resident.

On an identified date, a Staff Member said that resident #019 and resident #039 did not want to get up that morning for breakfast. Inspector #213 asked the Staff Member if these residents would be brought meal trays and the Staff Member said that the residents usually do not get trays when they do not want to get up; however, the residents would be given something off the morning snack cart.

In an interview with another Staff Member on another date, the Inspector asked if many residents stay in their room for breakfast and the Staff Member said that resident #019 never goes to the dining room for one identified meal. They said that this resident had milk and juice approximately two to three hours later. The Staff Member said they were not sure if the resident got juice that day. The Staff Member stated that resident #037 had gone to the dining room for that meal in many months and stays in their room. They said that the resident was happier and will be given juice, but is not provided or offered food.

In an interview with another Staff Member, the Inspector asked if resident #008 had been receiving meal trays prior to last week and the Staff Member answered no, the resident was getting specific items for breakfast, but they were not sure if the resident got anything on supper cart and did not get anything for lunch. They said that resident #008 could get something off the snack cart, and usually chose water. When asked if residents were offered food if they do not get up for a meal, the Staff Member said residents #037, #019, #036 and #038 do not go to the dining room for a specific meal. They said that #038 got a granola bar and residents could get something off the juice cart. The Staff Member said resident #019 got drinks off the cart, and because this resident was diabetic, the staff were not comfortable with the resident not getting anything.

Observations on an identified date, from 0845 to 0915 hours:
- Staff Member #115, entered lower hallway with a cart consisting of 2 trays with juice, milk, water and medications, entered resident #019's room and provided fluids, oral medications and insulin to resident #019 who was in their bed. No food was delivered or offered to resident #019.
- Staff Member #115 entered resident #020's room and provided milk, juice, water and medication to resident #020 who was in their bed. No food was delivered or offered to resident #020.
- No staff entered resident #036's room, brought in or offered fluids or food to resident #036 who was in their bed.
- No staff entered resident #037's room, brought in or offered fluids or food who was in their bed.

Inspector #213 asked Staff Member #115 about providing only fluids to residents #019 and #020 and the Staff Member responded yes, that these residents did not come to the dining room and preferred to stay in bed so there was no choice. The Staff Member said that resident #019 was diabetic and because the resident

received insulin in the morning, they were not comfortable with the resident having nothing, so fluids were provided.

In an interview with a Registered Dietitian (RD), Inspector #689 asked the RD if they would expect resident #008 to be offered food and fluids at all meal and snack times. The RD said that yes, they would expect this resident to be offered all meals and snacks along with fluids that are currently provided. The RD stated that short staffing may have impacted whether resident #008 and other residents had been offered meals and snacks in their rooms.

In an interview with the Director of Care (DOC), the point of care documentation of food and fluid intake for resident #008 was reviewed with the DOC and Inspector #689. The DOC said that the percentage of meal eaten for resident #008 was documentation related to oral intake only. The DOC followed up with Inspectors #689 and #213, and said that according to the nutrition recommendations and dietitian notes, resident #008 received breakfast in the morning and specific fluids in the evening. Inspector #689 asked the DOC if resident #008 should be offered lunch and dinner meals in addition to a breakfast meal. The DOC responded with no, and stated that the resident's nutritional recommendations were discussed with the dietitian and that was what was decided.

The Meal Flow Sheets were reviewed by Inspector #689, and documentation of meal intake were noted as follows:
- A review of the clinical records for resident #008 showed no documentation for 49/90 (54 per cent) of meal times in the past 30 days. Meal frequency was indicated as breakfast, lunch and dinner.
- A review of the clinical records for resident #019 showed no documentation for 25/90 (28 per cent) of meal times in the past 30 days. Meal frequency was indicated as breakfast, lunch and dinner.
- A review of the clinical records for resident #020 showed no documentation for 22/90 (24 per cent) of meal times in the past 30 days. Meal frequency was indicated as breakfast, lunch and dinner.

A review of the home's policy entitled "Pleasurable Dining" with a revision date of March 2018, stated in the procedures that "any diet changes, room changes, special requests, need for tray service, or other changes to the resident's nutrition care are communicated to Nursing and Dietary staff as soon as possible to ensure accuracy of each resident's meal service."

A review of the home's policy entitled "Meal Service"; revision date January 2015, stated in the procedures that "residents are offered a minimum of three meals daily. If a resident chooses to miss breakfast, a larger, nutritious morning (AM) snack is provided (Nursing will inform the kitchen of the needs of the resident) and the Nutrition Care Plan is changed to reflect the resident's preferences" were expected when providing meals to residents.

A review of the home's policy entitled "Tray Service" with a revision date of January 2018, stated in the policy: "socialization at mealtimes in a designated dining area is always preferred and tray service is provided on a temporary basis only." The policy also stated in the procedures, criteria for resident's eligibility for tray service included:
- Illness/outbreak procedures;
- Totally bedridden;
- Palliative care;
- Behavioural issues awaiting appropriate assessment, and causing disruption in the dining room;
- Resident's request for a specific occasion, e.g. eating with visitors in an approved area within the Home.

In addition, the procedures noted that the "names of residents requiring tray service are forwarded to Dietary staff as soon as possible, at least ½ hours prior to the beginning of each meal unless regularly on the tray. Kitchen Requisition is completed and given to the kitchen by the Registered Staff."

The licensee failed to ensure that three meals per day were offered to residents #008, #019, #020, #036, #037, #039.

The severity of this issue was determined to be a level 3 as there was actual harm/risk and the area of non-compliance is a Key Risk Indicator. The scope of the issue was a level 1 as it related to six residents out of all of the residents in the home. Compliance history was a level 2 as there was unrelated non-compliance in this subsection of the legislation. (689)

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

Jul 06, 2018(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 : 004

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

Pursuant to / Aux termes de :

O.Reg 79/10, 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.

2. For those complaints that cannot be investigated and resolved within 10 business days, an acknowledgement of receipt of the complaint shall be provided within 10 business days of receipt of the complaint including the date by which the complainant can reasonably expect a resolution, and a follow-up response that complies with paragraph 3 shall be provided as soon as possible in the circumstances.

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).

Order / Ordre :

The licensee must be compliant with r, 101(1) of the O. Reg 79/10.

Specifically, the licensee shall ensure the following:
a) Document all complaints/concerns as per the home's policy including:
- The nature of each verbal or written complaint;
- The date the complaint was received;
- The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- The final resolution, if any;
- Every date on which any response was provided to the complainant and a description of the response; and
- Any response made in turn by the complainant.

b) The documented record is reviewed and analysed for trends at least quarterly. The results of the review and analysis are taken into account in determining what improvements are required in the home. A written record is kept of each review and of the improvements made in response.

Grounds / Motifs :

1. The licensee has failed to 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 was dealt with as follows: A documented record was kept in the home that included:
- The nature of each verbal or written complaint;
- The date the complaint was received;
- The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
- The final resolution, if any;
- Every date on which any response was provided to the complainant and a description of the response; and
- Any response made in turn by the complainant.
The licensee has also failed to ensure that:
- The documented record was reviewed and analyzed for trends at least quarterly;
- The results of the review and analysis were taken into account in determining what improvements were required in the home; and
- A written record was kept of each review and of the improvements made in response.

The home's "Issues, Complaints and Concerns" policy, with a revision date of March 2016, was reviewed. The policy indicated:
"The Administrator shall ensure that all suggestions, complaints and concerns are documented and a record is maintained within the home that includes:
a. The nature of each verbal or written complaint;
b. The date the complaint was received;
c. The type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required;
d. The final resolution, if any;
e. Every date on which any response was provided to the complainant and a description of the response; and
f. Any response made in turn by the complainant.
The Administrator shall ensure that:
a. The documented record is reviewed and analyzed for trends at least quarterly;
b. The results of the review and analysis are taken into account in determining what improvements are required in the home; and
c. A written record is kept of each review and of the improvements made in response."

In an interview with the Director of Care (DOC), Inspector #213 requested to review the home's complaint documentation. The DOC said that they did not know where this was and was looking into it. The Inspector asked if there was a form that was filled out for complaints, the DOC did not know; that the Executive Director took care of complaints. The Inspector asked if a family voiced a complaint at supper time to a staff member, how would that complaint and information get to the Executive Director to take care of, the DOC said this would happen verbally.

The Administrator provided a binder of critical incidents with no complaints in it on March 22, 2018. The Administrator also provided a folder with three complaints in it. The Administrator shared that these were complaints that they were currently working on. The Inspector asked for 2017 complaints again on March 28, 2018, and the Administrator provided a binder of complaints documented by the previous DOC, but this documentation ended in June 2017. There was no documentation of any complaints received by the home for the remainder of 2017 provided.

The three complaints dated 2018 were reviewed and included complaint forms titled "Craigwiel Gardens Complaints and Concerns Form":

- A complaint regarding resident #022 indicated that the resident had not received a bath or had bedding changed in weeks. In addition, that the resident had been found during the night still up in a chair and asking to go to bed and roommates had asked for assistance for two hours with no staff assistance provided. The complaint stated that this was unacceptable and was because there was no staff. The complaint further stated that during an outbreak, the resident had not received a bath, a bed bath or sponge bath or had bed linens changed for three weeks. Documentation included a phone call with the complainant. Documentation of the explanation offered by the home during this phone call included that "no baths are administered during an outbreak".
- Another complaint regarding resident #022 indicated that the resident had not received a bath and was supposed to have two baths per week. The outcome documented included the resident received a bath the following day. The subsequent day, it was not reported that baths were missed and the missed bath was brought to the attention of the Administrator at a family council meeting. The Administrator spoke to the DOC and requested a plan be put in place to address missed baths in time of short staffing situations. It also indicated "Requires Further Action". There was no documentation of any further follow up or response to complainant.
- A complaint regarding resident #001 indicated that the resident had not received care, i.e. shaving and bathing. Documentation in this complaint included immediate verbal follow up with the complainant.

In an interview with the family of an identified resident, the family member shared that they voiced a complaint, regarding specific care and treatments, to the DOC. They said that although the complaint was resolved, they did not receive any follow up from the home related to the resolution of the complaint and they did not hear back from the DOC.

In an interview with the DOC, the Inspector asked if they were aware of the complaint from the family of resident #005 regarding specific care and treatments. The DOC said that they were aware of the complaint. The Inspector asked of the complaint was documented, the DOC said that the complaint was documented in the resident's progress notes in Point Click Care (PCC), that the complaint was resolved and to their understanding, there was no further follow up with the complainant needed.

The progress notes for resident #005 were reviewed in PCC, and a progress note was found regarding the family's concern regarding a treatment not provided for resident #005. Three days later, the home received a physician's order for the

treatment. On that date, the family of resident #005 called the home again to inquire if the treatment had been provided yet, and why it had not been done for several months previously. The family member spoke to a nurse who informed the family that they would be providing the treatment that day. The treatment was documented as completed on that date. There was no further documentation found regarding follow up with the complainant from the DOC, the home, or anyone else related to the resolution of their complaint, how it happened or what was done about it to prevent further issues.

The Inspector also asked the Administrator and the DOC for documentation of a review or analysis of complaints for 2017, for trends and improvements required. The home was unable to produce any documentation of any review or analysis of complaints received by the home in 2017 or 2018.

The licensee has failed to 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 was dealt with as follows: A documented record was kept in the home that included the nature of each verbal or written complaint, the date the complaint was received, the type of action taken to resolve the complaint, including the date of the action, time frames for actions to be taken and any follow-up action required, the final resolution, every date on which any response was provided to the complainant and a description of the response; or any response made in turn by the complainant. The licensee has also failed to ensure that the documented record was reviewed and analyzed for trends at least quarterly, the results of the review and analysis were taken into account in determining what improvements were required in the home and a written record was kept of each review and of the improvements made in response.

The severity of this issue was determined to be a level 2 as there was a potential for risk. The scope of the issue was a level 3 as it related to all residents in the home. The home had a level 3 history of one or more related non-compliance with this section of the Act that included: a voluntary plan of correction (VPC) issued May 17, 2017 (2017_605213_0005). (213)

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

Jul 31, 2018

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

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

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

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

Health Services Appeal and Review Board and the Director

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

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

À l'attention du/de la registrateur(e)
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 2T5

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

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

Issued on this 24 day of May 2018 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by RHONDA KUKOLY - (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

Service Area Office / Bureau régional de services : London