Ontario

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

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Central West District
609 Kumpf Drive, Suite 105
Waterloo, ON, N2V 1K8
Telephone: (888) 432-7901
centralwestdistrict.mltc@ontario.ca

Original Public Report

Report Issue Date: February 1, 2023	
Inspection Number: 2023-1268-0002	
Inspection Type: Proactive Compliance Inspection	
Licensee: Eden House Care Facility Inc.	
Long Term Care Home and City: Eden House Nursing Home, Guelph	
Lead Inspector JanetM Evans (659)	**Inspector Digital Signature**
Additional Inspector(s) April Racpan (218) Gurvarinder Brar (000687) was present at the inspection	

INSPECTION SUMMARY

The Inspection occurred on the following date(s):
January 5 - 6, 9 - 13, and 16 - 19, 2023

The following intake(s) were inspected:

- Intake: #00017358-Proactive Compliance Inspection

The following **Inspection Protocols** were used during this inspection:

Infection Prevention and Control
Quality Improvement
Medication Management
Residents' and Family Councils
Skin and Wound Prevention and Management
Falls Prevention and Management
Pain Management

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Safe and Secure Home
Food, Nutrition and Hydration
Resident Care and Support Services
Prevention of Abuse and Neglect
Residents' Rights and Choices

INSPECTION RESULTS

Non-Compliance Remedied

Non-compliance was found during this inspection and was **remedied** by the licensee prior to the conclusion of the inspection. The inspector was satisfied that the non-compliance met the intent of section 154 (2) and requires no further action.

NC #001 remedied pursuant to FLTCA, 2021, s. 154 (2)
O. Reg. 246/22, s. 148 (2) 3.

Rationale and Summary:
The licensee failed to ensure that drugs for that were to be disposed were stored safely and securely until the disposal occurred.

The home's policy for drug disposal said that drugs to be disposed of should be stored safely and securely within the home separate from medications for administration, until the destruction or disposal occurred.

Inspectors #659 and #000687 observed non controlled medications for disposal and destruction were in a back room of the medication room along with stock medications. There were four buckets with instructions above each of them telling staff how to dispose of the medications and in which bucket. Medication packages with Personal Health information (PHI) evident were lying on top of the buckets with various non-controlled medications in them. The bucket lids were not secured to the buckets and medications that were in some of the buckets could be accessed and removed.

An RPN told inspectors that staff were to remove the medications and put them in a bucket and the packages were to be put in a separate bucket for shredding.

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The DOC acknowledged the disposal area was not appropriately maintained. Staff did not follow their process.

On January 12, 2023 observations of the medication room showed the medications for disposal had been placed in each bin as directed by postings and bin lids had been applied.
[659]

Date Remedy Implemented: January 12, 2023

WRITTEN NOTIFICATION: Residents' Bill of Rights

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 3 (1) 12

The licensee has failed to ensure that a resident's right to access protected outdoor areas in order to be able to enjoy outdoor activities was supported.

Rationale and Summary:
A resident was independent with making their own decisions pertaining to their health and care tasks. They requested to go outside for some fresh air. The resident's request was denied due to weather and safety concerns.

The DOC said that arrangements were underway to accommodate the resident's request. However, six days later, the resident's request to go outside had still not been addressed by the home.

Not giving a resident access to outdoor areas in order to enjoy an outdoor activity placed them at minimal risk for experiencing negative emotional responses.

Sources: resident #010's profile and care plan, interviews with resident #010 and DOC #100.

[218]

WRITTEN NOTIFICATION: Quarterly evaluation

NC #003 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 124 (1).

The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care and the pharmacy service provider, met at

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least quarterly to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

Rationale and Summary:
During 2022, the Professional Advisory Committee (PAC) met once in March 2022. There were no other meetings held to review medication management.

The Director of Care said some meetings did not occur in 2022, related to outbreaks at the home.

Failure to complete a quarterly evaluation of the effectiveness of the medication management system and to recommend any changes necessary to improve the system may risk lost opportunities for enhancement of the system or implementation of corrective actions to decrease medication incidents.

Sources: PAC Meeting minutes -March 14, 2022, Interview with DOC
[659]

WRITTEN NOTIFICATION: Safe Storage of Drugs

NC #004 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 138 (1) (b)

The licensee failed to ensure that controlled substances were secured in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart.

The home's policy for drug storage of controlled substances said controlled substances must be stored separately in a double-locked area.

Inspectors # 659 and #000687 observed an RPN wheel the medication cart into the medication room and leave the room without locking the medication cart. A check of the cart showed several medication cards with signage sheets attached to them lying in the bottom drawer across bottles of medications.

An RN said the controlled substances should be secured. They could not lock them in the secure box in the medication cart as they did not have the key.

Failing to ensure that controlled substances were secured in a separate, double-locked stationary

cupboard in the locked area or stored in a separate locked area within the locked medication cart risks potential for controlled substances to go missing or unaccounted for.

Sources: Observations, Silver Fox Policy 7, Drug Storage, last revised March 2020 v. 2.9, interview with RN #116
[659]

WRITTEN NOTIFICATION: Medication Incidents and Adverse Drug Reactions

NC #005 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O.Reg. 246/22, s. 147 (3) (a)

The licensee failed to ensure that a quarterly review was undertaken of all medication incidents and adverse drug reactions that occurred in the home since the time of the last review in order to reduce and prevent medication incidents and adverse drug reactions.

Rationale and Summary:
PAC meeting minutes from March 2022, documented the pharmacy representative was unable to attend so a review of the medication incidents was not completed.

The DOC acknowledged medication incidents were not reviewed with the interdisciplinary team for the entire year.

Failure to complete a quarterly review of the medication incidents and adverse drug reactions is a missed opportunity to identify trends that could be addressed to prevent and reduce further incidents and adverse drug reactions.

Sources: PAC meeting minutes March 14, 2022. Medication incidents for Margaret and Mary Kelly, interview with DOC.
[659]

WRITTEN NOTIFICATION: Housekeeping

NC #006 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 93 (2) (b) (i).

The licensee has failed to ensure that cleaning and disinfection was implemented in accordance with the manufacturer's specifications for resident care equipment, specifically shower chairs and transfer lifts.

Rationale and Summary:
A) Posted on the wall of the shower room were directions to clean and disinfect the shower chair after each use. The disinfectant was readily available in the shower at time of observation.

A PSW stated that they had provided a shower a resident and had cleaned the shower chair with hot water following its use. They were not aware they were supposed to disinfect the chair following each use.

The manufacturer instructions for the shower chair stated it should be disinfected by wiping down all generally accessible surfaces with disinfectant. It could be cleaned and disinfected using commercially available agents.

The Housekeeping and Laundry supervisor said the cleaning and disinfection should be completed after each use.

Failure to follow the manufacturer's instructions for cleaning and disinfecting shared resident equipment risks potential transmission of micro-organisms to residents and staff.

Sources: Observation, Invacare Aquatec Ocean User Manual, shower room posting, interview with Housekeeping/Laundry supervisor and staff.
[659]

B) The home used low-level disinfectant wipes for the purpose of cleaning and disinfecting resident shared equipment, such as mechanical transfer lifts. As per the manufacturer's instructions related to the cleaning and disinfection of lifts, the equipment should be cleaned between use of different patients and/or when suspected to be contaminated.

Two PSW staff entered a resident's room to obtain their weight, using a mechanical lift. They did not clean or disinfect the equipment before or after completing the resident care task. One PSW was unsure if the home had protocols in place related to cleaning and disinfecting transfer equipment and acknowledged that they did not implement this practice at the home.

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Not cleaning or disinfecting resident shared equipment as per the manufacturer's instructions placed residents at potential risk for transmitting and contracting infection diseases.

Sources: Manufacturer's Instructions – "Care and Preventative Maintenance; General Lift Care" and "Care of your Maxi Move; Sling Cleaning and Care; Lift Cleaning and Care", observation on January 9, 2023, and interview with PSW #112.
[218]

WRITTEN NOTIFICATION: Infection Prevention and Control Program

NC #007 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 102 (10).

The licensee failed to ensure that the information gathered under subsection (9) was analyzed daily to detect the presence of infection and reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Rationale and Summary:
IPAC lead said they reviewed the information on PCC daily and contacted public health if needed to discuss resident symptoms. On weekends staff would notify the DOC or ED of any resident symptoms.

The IPAC lead stated they implemented the daily tracking form in the home in January 2023.

The DOC stated that prior to the IPAC lead starting, the ED had been responsible for this surveillance.

No documentation was provided that daily analysis or a monthly review of information gathered under s. 102 (9) had been completed for 2022.

The ED acknowledged no monthly review of information collected under subsection (9) was reviewed at least once a month to detect trends, for the purpose of reducing the incidence of infection and outbreaks.

Failure to complete a daily analysis of the information collected under subsection 9, or a monthly review of information collected under subsection 9 to detect trends may risk potential recurring transmission of micro-organisms to residents or staff, or outbreaks.

Sources: Surveillance document, interviews with ED, IPAC lead
[659]

WRITTEN NOTIFICATION: Orientation

NC #008 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 259 (2) (f).

The licensee has failed to ensure that training for staff in infection prevention and control required under paragraph 9 of subsection 82 (2) of the Act included cleaning and disinfection practices.

Rationale and Summary:
Two PSWs did not recall receiving IPAC training from the home. Both staff had initialed this as completed on their orientation checklist. One PSW was shown the Annual education booklet which contained self study training information including but not limited to IPAC but they had not recalled receiving or reviewing this booklet.

The IPAC lead and Unit Clerk stated that laundry and housekeeping supervisor was responsible to train staff on cleaning and disinfecting of equipment.

The Laundry and housekeeping supervisor said they had not completed this training with the PSWs.

Failure to ensure that IPAC training is completed for staff related to cleaning and disinfecting of equipment risks knowledge deficits for staff which could lead to potential risk of transmission of pathogens or infections for residents who utilize shared equipment in the home.

Sources: orientation education sign off, interviews with IPAC lead, Housekeeping/Laundry supervisor, Unit Clerk and staff.
[659]

WRITTEN NOTIFICATION: Additional training- direct care staff

NC #009 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 261 (1).

The licensee has failed to ensure that training was provided to all direct care staff for the following

programs: Falls prevention and management, Skin and wound care, and Pain management.

Rationale and Summary:
Pursuant to paragraph 6 of subsection 82 (7) of the FLTCA, the licensee is required to ensure that all staff who provide direct care to residents receive training in any other areas provided for in the regulations.

As per O. Reg 246/22 s. 261 (1), the licensee is required to ensure that all direct care staff received training in the following areas:
-1. Falls prevention and management
-2. Skin and wound care
-4. Pain management, including pain recognition of specific and non-specific signs of pain.

None of the home's direct care staff, including Personal Support Workers (PSW), registered staff, and two of the designated leads of the programs received training in the above areas.

The Pain Lead was not familiar with the home's pain management program, including the policies and procedures, care planning approaches, and pain assessment tools.

An RN said that they were not aware that the home had an existing pain management program. Additionally, they were not familiar with the home's skin and wound policies and therefore relied on their nursing judgment for completing skin and wound assessments.

The DOC said that training and education of the required programs was currently not a part of the home's orientation and annual re-education process for direct care staff.

There was potential risk when training and education of the required programs were not provided to all direct care staff. This increased the likelihood that appropriate care would not be in place when addressing care concerns related to falls, skin and wound, and pain management.

Sources: home's staff training records, interviews with the Pain Lead, RN #116, and DOC #100.
[218]

WRITTEN NOTIFICATION: General Requirements for programs

NC #010 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 34 (1) 1

The licensee has failed to ensure that a written description of the programs included methods to reduce risk and monitor outcomes, and protocols for the referral of residents to specialized resources where required.

Rationale and Summary:
A) The written description of the Falls Prevention program documented that the registered staff would make referrals to interdisciplinary team members. There was no documentation as to who should be notified internally, when they should be notified, how they should be notified and when to notify external resources.

The Falls lead stated that the protocol or process for referrals to specialized resources was that after a fall there would be referrals to physio, physician, and falls team. External referrals were completed by the physician.

The DOC said they tell staff the process to specialized resources during their orientation, but it was not formally documented in their program or policies.

Not having a written description that included protocols for the referral of resources, placed residents at risk for not receiving appropriate care in the event that specialized resources were required.

Sources: Falls Prevention program, last reviewed 3/20, interview with Falls lead and DOC
[659]

B) The home's Pain management and Skin and Wound programs did not include protocols for the referral of residents to specialized resources where required.

An RN said that any referrals related to obtaining specialized resources were forwarded to the DOC. The home did not have access to a Skin and Wound specialist, and they were unsure how to access specialized resources, in the event that it was required.

The DOC acknowledged that the home did not have a written protocol for the above programs related to completing referrals for residents to specialized resources where required. They said the expectation was to consult with the physician and send the resident to the hospital, if specialized resources were required.

Not having a written description that included protocols for the referral of resources, placed residents at risk for not receiving appropriate care in the event that specialized resources were required.

Sources: Section 2 Programs, Subsection 2.14 Pain Management Program, date reviewed: March 2020, Section 2 Programs, Subsection 2.24 Wound and Skin Care Program, date reviewed: March 2020, interviews with RN#116 and DOC #100.
[218]

WRITTEN NOTIFICATION: General Requirements for programs

NC #011 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with O. Reg 246/22 s. 34 (1) 4.

The licensee has failed to ensure that there was a written record of the evaluation programs that included a summary of changes that were made, and the date that the changes were implemented.

Rationale and Summary:
The home’s policies stated the interdisciplinary team were required to review the Falls Prevention, Skin and Wound, and Pain management programs annually to determine the effectiveness of the programs and to identify changes to improve the programs.

The home completed their annual evaluations for the Falls prevention, Skin and wound care, and Pain management programs in October 2022.

Despite the records indicating that the above programs were reviewed during the annual evaluation, the DOC clarified that the policies had not been reviewed or revised since March 2020. The annual evaluation records included goals for the programs, but the home was not able to produce a written record related to the summary of changes made and the dates of when changes were implemented to the programs.

Sources: Home’s annual program evaluation records, Section 2 Programs, Subsection 2.14 Pain Management Program, date reviewed: March 2020, Section 2 Programs, Subsection 2.24 Wound and Skin Care Program, date reviewed: March 2020, and interviews with DOC #100.
[218]

WRITTEN NOTIFICATION: Duty of licensee to consult with Councils

NC #012 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 73.

The licensee failed to complete their duty to consult regularly with the Residents' Council, and with the Family Council, at least every three months.

Rationale and Summary
Residents' Council and Family Council met once each in 2022.

The Administrator or Director of Care were not in attendance at the Family Council meeting.

The ED acknowledged that they had not met quarterly to consult with either council.

Failure of the licensee to consult regularly with Residents Council and Family Council and at least every three months is an opportunity lost to share and exchange information and hear feedback of what is working or nor working well in the home.

Sources: Residents' Council minutes dated April 2022, Family Council minutes date June 15, 2022, Interviews with Recreation manager, President of Residents' Council, Family Council attendee.

WRITTEN NOTIFICATION: Continuous quality improvement committee

NC #013 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: O.Reg. 246/22, s. 166 (2)

The licensee failed to ensure their continuous quality improvement (CQI) committee was composed of at least the following persons:
1. The home's Administrator.
2. The home's Director of Nursing and Personal Care.
3. The home's Medical Director.
4. Every designated lead of the home.
5. The home's registered dietitian.
6. The home's pharmacy service provider, or where the pharmacy service provider is a corporation, a pharmacist from the pharmacy service provider.

7. At least one employee of the licensee who is a member of the regular nursing staff of the home.
8. At least one employee of the licensee who has been hired as a personal support worker or provides personal support services at the home and meets the qualification of personal support workers referred to in section 52.
9. One member of the home's Residents' Council.
10. One member of the home's Family Council, if any

Rationale and Summary:
The home's Continuous Quality improvement team, had not included the following required roles: registered dietitian, at least one employee who was a member of the regular nursing staff, at least one employee who was hired as a personal support worker, one member of Residents' Council, and one member of Family Council.

The ED acknowledged that their CQI team did not include all the required members.

Not including all required roles in the CQI committee may risk potential relevant interdisciplinary feedback not being included to assist the home in their CQI initiatives or outcomes.

Sources: 1.6 Teams and Committees, revised February 2020, interview with ED.
[659]

WRITTEN NOTIFICATION: Continuous quality improvement initiative report

NC #014 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: O. Reg. 246/22, s. 168 (6).

The licensee failed to ensure that the interim report prepared under subsection (5) was
(a) published on the home's website, subject to section 271;
(b) provided to the Residents' Council and Family Council, if any; and
(c) included,

i. the name and position of the designated lead for the continuous quality improvement initiative,
ii. a written description of the home's priority areas for quality improvement, objectives, policies, procedures and protocols for the continuous quality improvement initiative,
iii. a written description of the process used to identify the home's priority areas for quality improvement, and

iv. a written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement.

Rationale and Summary:
A) Review of the home's website showed an excerpt of the home's interim CQI report had been posted to the website instead of the full report.

B) There was one Residents' Council meeting and one Family Council meeting completed in 2022. Minutes of those meetings did not indicate that a copy of the interim CQI report had been provided to the Councils.

No other documentation was provided to show that the Residents' and Family Councils had received a copy of the interim CQI report.

C) Review of the home's website showed the excerpt of the interim CQI report was posted but did not include the name and position of the designated lead for the CQI initiative.

D) The Interim CQI report documented a written description of the home's priority areas for quality improvement and objectives for 2022/23. However, the report did not include written descriptions of relevant policies, procedures and protocols which related to all of the identified CQI initiatives.

E) The home's interim CQI report and Narrative, QIP 2022/23 posted to their website included a written description of the process used to identify the home's priority areas for quality improvement. The narrative stated that the home selected indicators and incorporated opportunities for improvement that were identified in part, through the Resident Satisfaction Survey, however there had not been a Resident Satisfaction Survey completed at the home since 2019.

F) The written description of a process to monitor and measure progress, identify and implement adjustments, and communicate outcomes for the home's priority areas for quality improvement was not included in the information posted to the home's website.

The ED acknowledged that some items that were required to be posted were missing from the website posting and that information had not been shared with the Residents' and Family Council meetings.

Failure to ensure the interim CQI report which was posted in the home and on the home's website included all the required information and to ensure the report was shared with the Residents' Council

and Family Council may limit the ability of residents, family members, caregivers or the public to understand the quality initiatives, how the home will monitor/measure progress and report outcomes, who to contact if they have questions or concerns about the quality initiatives.

Sources: Interim CQI report 2022/23, Resident's Council minutes -April 2022, Family Council minutes – July 2022. Interview with ED.
[659]

WRITTEN NOTIFICATION: Resident and Family/Caregiver Experience Survey

NC #15 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

Non-compliance with: FLTCA, 2021, s. 43

The licensee failed to ensure that:
- a survey was taken of residents, their families and caregivers at least once a year unless otherwise directed by the Minister
-every reasonable effort to act on the results of the survey and improve the long-term care home and the care, services and goods provided at the home accordingly
-the advice of Residents' Council and Family Council were sought in carrying out the survey
-the results of the survey were documented and made available to the Residents' Council and Family Council
- the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any;

Rational and Summary:
A resident survey had not been completed for 2021 or 2022. A family or caregiver survey had not been completed in 2021 but was completed in March of 2022. There had been no analysis of the responses within the surveys.

The Resident Council president and a Family Council attendee said the home had not sought the advice of the Councils related to carrying out the surveys or acting on the results.

Results of the 2022 family survey had not been documented and shared with either Residents' or Family Council.

Failure to complete a survey of residents, family members and caregivers or seek input from Residents' and Family Councils in carrying out or acting on the results of the survey is a missed opportunity to collaborate with residents and families and capture information of importance to residents and family members

Sources: Residents' and Family Council meeting minutes 2022, Residents' surveys 2018 and 2019, Family Survey 2019 and 2022, interviews ED #101, Residents' Council president #010, Family Council representative #115.
[659]

COMPLIANCE ORDER CO #001 Bathing

NC #001 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.

Non-compliance with: O. Reg. 246/22, s. 37 (1).

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:

The licensee shall:

1) Develop a written bathing protocol to ensure that residents receive a minimum of two baths per week according to their preference. The protocol must include clear directions for staff to follow when a resident does not receive their scheduled bath.

2) Educate all direct care staff, including PSWs and registered staff, on the home's bathing protocol.

3) Complete a weekly audit for the completion and documentation of resident baths. Ensure all residents receive their baths according to the schedules and preferences and that bathing tasks including missed/refused baths, and any other actions taken are documented. The audits shall continue for a minimum of four weeks or until compliance has been achieved.

4) Maintain a written record of steps 1-3. This must include the following:
-date(s) of when the protocol was developed,
-date(s) of when the education was provided,
-name(s) of the person(s) responsible for the training and audits
-the signatures of the participants who attended the training
-any corrective actions taken related to the audit records

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Grounds
Non-compliance with O. Reg 246/22 s. 37 (1).

The licensee has failed to ensure that multiple residents of the home were bathed, at a minimum, twice a week.

Rationale and Summary
The home established an internal bathing process that included two direct care staff members that were responsible for completing daily baths for residents identified on a bathing schedule. If baths were missed or refused, the direct care staff were responsible for documenting the information using a specific bath form, and then providing it to the registered staff for follow-up actions. The registered staff were then required to document the follow-up actions taken related to staff replacement, family notification, and rescheduling of bath days.

The home did not have a written description of the home's bathing protocol, as described above.

A review of the home's bathing records showed that multiple residents did not receive their scheduled baths between December 6, 2022 and Jan 12, 2023. In total, there 76 incidents where residents had not received their baths.

A review of the home's bathing forms and care task records demonstrated that alternative bathing options were not provided to multiple residents and the missed baths were not rescheduled for the dates mentioned above. The actions taken by the registered staff were not always documented on the bath forms.

Two residents expressed their concerns related to not receiving their scheduled baths regularly and said it was an ongoing problem at the home. One resident said there were times when they did not receive a bath or have their hair washed for a full week.

A PSW who was one of the home's designated bath team members shared that baths were often impacted due to staffing operations, resulting in the above bathing tasks not provided or rescheduled. They said that on the days they worked alone, baths were not provided to the residents that required more than one staff assistance.

An RPN said they were not familiar with the home's internal bathing process and of their responsibilities on completing the required follow-up actions. They said they had never seen the bath forms before, and therefore had not documented any actions taken related to missed baths.

The DOC said that the bath forms were not always completed in a timely manner, making it difficult to

track the missed bath days. Consequently, they said it was a challenge for the home to make up the missed baths, especially when baths were not provided for two days in a row.

Failure to ensure that the residents received their scheduled baths twice a week placed them at actual risk for poor personal hygiene, and other care concerns.

Sources: home's bathing records and PCC Documentation Survey Reports, interviews with residents #009, #010, PSW #113, RPN #117, and DOC #100.
[218]

This order must be complied with by March 17, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). 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 or AMP was served on the licensee.

The written request for review must include:

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

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

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 an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

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

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

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