Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jun 28, 2018	2018_671684_0013	010480-18	Resident Quality Inspection

Licensee/Titulaire de permis

Extendicare (Canada) Inc.
3000 Steeles Avenue East Suite 103 MARKHAM ON L3R 4T9

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

Extendicare Falconbridge
281 Falconbridge Road SUDBURY ON P3A 5K4

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

SHELLEY MURPHY (684), MICHELLE BERARDI (679), RYAN GOODMURPHY (638), SHANNON RUSSELL (692)

Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): June 11-15, 2018, and June 18-22, 2018.

The following intakes were inspected during this Resident Quality Inspection:

Compliance Order (CO) #001 from Inspection report #2018_745690_0002, s. 6 (10) of the Long-Term Care Homes Act (LTCHA),2007, specific to ensuring that the resident's are reassessed and the plan of care reviewed and revised at least every six months and at any other time;

Two Critical Incidents (CIs), related to infection prevention and control program;

Four CIs, related to falls prevention and management;

One CI, related to an allegation of staff to resident abuse;

One CI, related to an allegation of resident to resident abuse;

One complaint submitted to the Director relating to staffing levels in the home;

One complaint submitted to the Director regarding a bed refusal, and;

One complaint submitted to the Director relating to resident care.

The inspectors also conducted daily tours of the resident care areas, observed the provision of care and services to residents, reviewed relevant licensee policies, procedures, programs, internal investigation files, human resource files and resident health care records.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Director of Cares (ADOCs), Social Worker (SW), Physiotherapist (PT), Registered Dietitian (RD), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and their families.

The following Inspection Protocols were used during this inspection:

Admission and Discharge
Continence Care and Bowel Management
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Residents' Council
Responsive Behaviours
Skin and Wound Care
Sufficient Staffing

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

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

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 6. (10)	CO #001	2018_745690_0002	684

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

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

Specifically failed to comply with the following:

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

s. 6. (9) The licensee shall ensure that the following are documented:
1. The provision of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
2. The outcomes of the care set out in the plan of care. 2007, c. 8, s. 6 (9).
3. The effectiveness of the plan of care. 2007, c. 8, s. 6 (9).

Findings/Faits saillants :

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

Resident #001 was identified as having altered skin integrity through their Minimum Data Set (MDS) assessment and during a staff interview with Inspector #638.

During a review of resident #001's physician orders and electronic treatment administration record (eTAR) records, Inspector #638 identified that the resident had multiple areas of altered skin integrity.

Inspector #638 reviewed the physician orders and noted an order on a specified date in 2018, which indicated instructions for treating an area of altered skin integrity. The Inspector was unable to identify the specific area of altered skin integrity that the order was directing to treat.

In an interview with Inspector #638, Registered Practical Nurse (RPN) #122 indicated, that when orders were received the care plan was to be updated and the previous order discontinued. RPN #122 also indicated upon reviewing the physician order from a specified day in 2018, that the order should have been clearer to indicate the area of altered skin integrity the order was directing to treat.

The home's policy titled "Care Planning - RC-05-01-01" last updated April 2017, indicated that the plan of care is a series of documents that provides information or instructions to the care team regarding the assessed needs, delivered care and outcomes of care.

In an interview with Inspector #638, the Director of Care (DOC) indicated that the physician order written on a specified day in 2018, lacked clarity and required clarification for the site of the altered skin integrity. [s. 6. (1) (c)]

2. The licensee has failed to ensure that the provision of the care set out in the plan of care was documented.

Resident #009 was identified as having experienced a weight change through a record review completed by Inspector #684. The Inspector reviewed the "survey report v2" over a two week period, and noted that on one specific day there was no documentation for one meal intake. It was also noted on a second day that there was no meal intake documentation for two meals.

Inspector #684 interviewed RPN #103, regarding the meal intake for resident #009. RPN #103 stated that the meal intake was to be documented in Point of Care (POC) everyday for breakfast, lunch, supper and nourishment. RPN #103 confirmed that resident #009 was in the facility for all meals on both of the specified days noted. The RPN confirmed that documentation was missing for a meal on one specific day and two meals on the other specified day. RPN #103 also noted that there was no documentation in Point Click Care (PCC) by registered staff to indicate the meal intake for the two specified dates.

Inspector #684 reviewed the policy titled Meal Service RC-18-01-07, last updated February 2017. In the procedure section #7, it indicated "Care Staff- Document intake of food and fluid and/or special items either on paper or electronically."

Inspector #684 interviewed the DOC who indicated that there should always be documentation for each meal, to indicate meal intake or meal refusal. [s. 6. (9) 1.]

3. During a record review, Inspector #638 noted that resident #001 was hospitalized on a specified date in 2018, and re-admitted a few days later with a specific medical device in place.

Inspector #638 reviewed resident #001's health care records and identified a physician's

order to discontinue the medical device on a specified date, that the resident returned with from the hospital. The Inspector reviewed the progress notes and the tertiary care centre notes and was unable to identify any indication that resident #001 had the medical device removed.

In an interview with Inspector #638, RPN #113 indicated that the tertiary care centre managed resident #001's medical device and they were not sure if the resident still had the device in place. RPN #113 observed resident #001 and identified to Inspector #638 that the medical device had been removed, RPN #113 then reviewed the resident's health care records and progress notes and was unable to identify when the medical device was removed or who removed the device. The RPN indicated to Inspector #683 that the care that was provided to resident #001 regarding the medical device should have been documented.

During an interview with Inspector #638, the DOC indicated that the tertiary care centre managed the specific medical device at the home. The DOC reviewed the resident's health care records and reported that there was a request to have the medical device removed on a specified day in 2018. The DOC stated that the physician ordered the removal of the medical device and the order was faxed to the tertiary care centre. Prior to the tertiary care centre removing the device, the resident removed the device on their own. The DOC indicated that there was likely no documentation on the removal because the resident removed it themself, but staff should have written a progress note indicating what had occurred. [s. 6. (9) 1.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 8. Nursing and personal support services

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that there was an organized program of personal support services for the home to meet the assessed needs of the residents.

A complaint was submitted to the Director, which alleged that the home was frequently short staffed and "things just are not being done".

In an interview with Inspector #638, resident #054 indicated that the home was always short staffed and they had to wait longer to receive personal care. The resident stated that the missed care was not provided at a later time.

Inspector #638 interviewed resident #034, who indicated that the home worked short staffed at times. The resident indicated that the residents' care was sometimes missed when short staffed and that the care was attempted to be provided on the following day, but that didn't always happen.

Inspector #638 reviewed the home's staffing levels during a specified time frame in 2018. The Inspector noted that the home worked short staffed in plan "c", "d" or "e" 27 out of 30 days in one month in 2018 (90 per cent of the days).

The Inspector reviewed the "Staffing Plan for Extendicare Falconbridge" which identified the number of Personal Support Workers that were to be scheduled on each floor for each shift.

In an interview with Inspector #638, the DOC indicated that;
-plan "c" means the floor worked two PSWs short;
-plan "d" means the floor worked three PSWs short; and
-plan "e" means the floor worked four PSWs short.

The Inspector reviewed three dates selected from a specified month in 2018, in which the home worked short staffed.

a) On one day in 2018, the third and fourth floor day shift worked in plan “c” and the second, third and fourth floor evening shift worked in plan “d”.
The Inspector reviewed the "Follow Up Question Report", which documents the care provided to all residents specific to bathing on each floor, and identified that on the specified day in 2018, residents #043, #045 and #046 on the second floor, residents #003, #032, #033, #034, #035 and #036 on the third floor and residents #019 and #020 on the fourth floor had bathing documented as “Activity Did Not Occur” or “Not Applicable”.

b) On a second specified day in 2018, the third and fourth floor day and evening shift worked in plan “c” and second floor day and evening shift worked in plan “d”.
The Inspector reviewed the "Follow Up Question Report", which documents the out come of care provided to all residents specific to bathing on each floor, and identified that on the second specified day, residents #047, #048, #049, #050, #051 on the second floor and residents #018, #021, #022, #023, #024, #025, #026 and #027 on the fourth floor had their bathing documented as “Activity Did Not Occur” or “Not Applicable”.

c) On a third day in 2018, the second and fourth floor day shift working in plan “c” and the second, third and fourth floor evening shift worked in plan “d”.
The Inspector reviewed the Follow Up Question Report, for bathing, on each floor and identified, residents #052 and #053 on the second floor, residents #037, #038, #039, #040, #041 and #042 on the third floor and residents #028, #029, #030 and #031 on the fourth floor had their bathing documented as “Activity Did Not Occur” or “Not Applicable”.

During separate interviews with Inspector #638, PSWs #146, #116, #142, #126, #141 and #107 each indicated that the home had significant staffing issues during a specific month. Each PSW stated that they ensured resident safety, but some scheduled care interventions were frequently missed due to workload when working plan “c” and plan “d”. PSWs #146, #141 and #116 stated that a care intervention was documented as “Not Applicable” if it was not completed and PSW #126 indicated that “Activity Did Not Occur” was also documented when a care intervention was not provided.

In an interview with Inspector #638, PSW #142 stated that registered staff were notified when resident care was not completed, so the next shift could provide the care. The PSW then indicated baths were rarely provided during that time period, because the next

shift was likely short staffed as well.

The Inspector reviewed the Follow Up Question Report looking specifically at bathing and noted that 34 of the 36 aforementioned resident's did not have their bath provided prior to their next scheduled bath, and residents #020, #032, #033, #034, #003 and #046 missed two consecutive baths.

During interviews with Inspector #638, RPN #114, RN #148 and #149 each indicated that staffing levels were worse in a specified month in 2018. They indicated that baths were pushed back to ensure that the "rest" of the care was completed. If the bath was missed during the shift it would be reassigned to the next shift. RN #149 stated that although the baths were reassigned, they were most likely not provided until the next scheduled bath. RN #148 stated that direct care staff documented missed baths as "Activity Did Not Occur" or "Not Applicable".

Inspector #638 interviewed the DOC, who indicated that there was a turnover in staff in the specified month in 2018, which caused frequent staffing shortages in the home while they were recruiting. When asked if they believed it would be reasonable to complete all the required care when working short staffed, this frequently, in plan "c" and plan "d" (90 per cent of the days, in one month in 2018) the DOC stated they didn't think it was possible, staff completed the care they were able to accomplish. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents, to be implemented voluntarily.

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

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a resident exhibiting altered skin integrity was assessed by a registered dietitian who was a member of the staff of the home and any changes made to the resident's Point of Care (POC) related to nutrition and hydration were implemented.

Resident #012 was identified as having altered skin integrity by Inspector #684 through a record review and a staff interview.

Inspector #692 completed a review of resident #012's care plan and eTAR, which indicated the resident currently had altered skin integrity to a specified area on their body.

Through the record review the Inspector was unable to locate documentation that a referral was completed and sent to a Registered Dietitian (RD) when it was identified that resident #012 had altered skin integrity.

The home's policy titled "Skin and Wound Program: Wound Care Management #RC-23-01-02, last reviewed February 2017, indicated that registered staff were to complete a referral to the RD, as the RD was to complete an assessment updating the residents nutritional interventions for all residents exhibiting altered skin integrity, including

pressure ulcers.

During an interview with Inspector #692, RPN #112 stated when a resident has altered skin integrity, registered staff were required to complete a referral to the RD. RPN #112 reviewed resident #012's electronic health records and stated that a referral was not sent to the RD when resident #012 was identified as having an area of altered skin integrity.

During an interview with Inspector #692, Registered Nurse (RN) #106 said when a resident develops altered skin integrity the registered staff were to send a referral to the RD. RN #106 stated they could not see evidence of a referral being completed and sent to the RD, for resident #012's new area of altered skin integrity.

During an interview with Inspector #692, RD #136 stated that registered staff were to send a referral to the RD as they were to complete an assessment and update the nutritional needs of the resident for all residents that have altered skin integrity. RD #136 stated "this got missed", confirming they had not received a referral for resident #012 who developed an area of altered skin integrity and therefore they had not completed an assessment of resident #012's nutritional needs.

Inspector #692 interviewed the DOC who stated it was an expectation that a referral be sent to the RD for all residents exhibiting altered skin integrity. The DOC confirmed there was no referral sent to the RD. [s. 50. (2) (b) (iii)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that a resident exhibiting an area of altered skin integrity is assessed by a registered dietitian and that changes are made to the residents plan of care relating to nutrition and hydration, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that a person who had reasonable grounds to suspect that any of the following had occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director: Misuse or misappropriation of a resident's money.

A Critical Incident Inspection Report was submitted to the Director for suspected misuse/misappropriation of resident's money which occurred in 2017.

Inspector #684 reviewed the investigation notes for the critical incident, which indicated that the Administrator and previous DOC #145 became aware on a specified date in 2017, that PSW #144 and resident #010 were discussing the purchase and sale of the resident's items to PSW #144. PSW #144 was the primary care giver for resident #010 at the time of the incident.

Further documentation from a specified date in 2017 indicated that there was a meeting held with PSW #144 which discussed the relationship and interactions between resident #010 and PSW #144. This document was signed and dated by the previous DOC #145 on a specified date in 2017.

During an interview between Inspector #684 and the Administrator stated that they became aware of the incidents between PSW#144 and resident #010 on a specified day in 2017. Administrator #140 stated this incident should have been reported to the ministry immediately on that day in 2017. [s. 24. (1)]

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:
5. Mood and behaviour patterns, including wandering, any identified responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day. O. Reg. 79/10, s. 26 (3).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care was based on, at a minimum, an interdisciplinary assessment of the resident's mood and behaviour patterns, including wandering, any responsive behaviours, any potential behavioural triggers and variations in resident functioning at different times of the day.

Resident #004 was identified as experiencing behaviours through their Minimum Data Set (MDS) assessment.

Inspector #679 reviewed the MDS assessment which identified that resident #004 exhibited behavioural symptoms and that this occurred one to three days in last seven days. The associated note provided an example of resident #004's exhibited behaviour.

In an interview with Inspector #679, PSW #116 identified that resident #004 would exhibit behaviours towards staff if a certain task was not completed in a specified time frame. PSW #116 identified that this behaviour can occur around three times per week. PSW #116 identified that a resident's behaviours and interventions to manage the behaviours would be indicated in the plan of care.

Inspector #679 reviewed the health care record which included the plan of care, and was unable to locate a focus or goal that identified resident #004's potential to exhibit responsive behaviours.

In an interview with RN #130 they identified that information regarding a residents behaviours, and the interventions to manage the behaviours would be located in the

residents care plan. Inspector #679 and RN #130 reviewed the electronic care plan, and identified there was no focus or goals related to behaviours for resident #004.

In an interview with Assistant Director of Care (ADOC) #121 they indicated that if resident #004 was experiencing behaviours, that this should have been included within the care plan. Inspector #679 and ADOC #121 reviewed the electronic care plan and did not identify a focus or goal related to the identified behavior for resident #004. [s. 26. (3) 5.]

2. The licensee has failed to ensure that the plan of care was based on, at a minimum, interdisciplinary assessment of special treatments and interventions.

Inspector #638 noted that resident #001 was hospitalized on a specified date in 2018, and re-admitted on a later date in 2018, for a change in their health condition. The Inspector reviewed the resident's health care records and identified that the resident returned from hospital with a medical device in place.

The Inspector reviewed the discharge instructions for the medical device included in the residents health care record, which provided general instructions for care.

The Inspector reviewed the resident's care plan and was unable to identify any specific instructions directing staff on the maintenance of the medical device.

During an interview with Inspector #638, RPN #113 indicated that upon return from hospital, a resident would be assessed and a review of treatment orders would be completed. The RPN stated that if there was a change in the care orders the registered staff would update the care plan. When asked if resident #001 had a medical device, the RPN reviewed resident #001's health care records and was unable to identify the status of the resident's medical device as it was not indicated within the care plan. The RPN indicated that the medical device was managed by the a tertiary care centre, however, it should have been identified within the care plan.

The home's policy titled "Care Planning - RC-05-01-01" last updated April, 2017, indicated that the care plan was a guide that directs care that is provided to the resident. The care plan must be resident-specific and customized to each resident's needs.

In an interview with Inspector #638, the DOC indicated that upon return from hospital registered staff review changes and update interventions in the resident's care plan. The

have been left out of the resident's care plan as this was not a responsibility for the home's staff to manage. The DOC indicated, moving forward, it should be identified in the care plan, as the home's staff would have been responsible for reporting any changes to tertiary care centre. [s. 26. (3) 18.]

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 33. Bathing

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

A complaint was submitted to the Director, which alleged that the home was frequently short staffed and "things just are not being done". Please see WN #2 for details.

The Inspector reviewed the Follow Up Question Reports specifically looking at bathing for all residents in the home on three specific dates in 2018.

a) Inspector #684 reviewed the residents' care records on each floor and identified that on one day in 2018, eleven residents had their scheduled bath documented as "Activity Did Not Occur" or "Not Applicable".

b) The Inspector reviewed the residents' care records on each floor and identified on a second day in 2018, thirteen residents had their scheduled bath documented as "Activity Did Not Occur" or "Not Applicable".

c) The Inspector reviewed the residents' care records on each floor and identified on a third day in 2018, twelve residents had their scheduled bath documented as "Activity Did

Not Occur” or “Not Applicable”.

In interviews with Inspector #638, multiple PSWs stated that a scheduled bath was documented as “Not Applicable” or "Activity Did Not Occur" if it was not completed or provided, and registered staff were notified when resident care was not completed, so the next shift could complete it.

Inspector #638 reviewed the health care records and noted that 34 of the 36 aforementioned resident’s did not have their scheduled bath made up prior to their next scheduled bath and six residents missed two consecutive baths.

During interviews with Inspector #638, RPN #114, RN #148 and #149 each indicated that if a scheduled bath was missed during the shift it would be reassigned to the next shift. RN #148 stated that direct care staff documented missed interventions as “Activity Did Not Occur” or “Not Applicable”.

The home’s policy titled “Bathing, Showering and Water Temperature Monitoring - RC-06 -01-02” last updated April 2017, indicated that each resident will receive a tub bath or shower, as mandated by provincial requirements. In Ontario, residents will be offered a tub bath or shower, based on resident preference, twice per week, at minimum.

In an interview with Inspector #638, the DOC stated if care was missed it was supposed to be scheduled for the next shift or the next day. When asked if it was acceptable that the care was missed this frequently and not made up, the DOC indicated that it was not and the staff should have provided the resident care. [s. 33. (1)]

Issued on this 10th day of July, 2018

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

Original report signed by the inspector.