Ontario

Ministry of Health and Long-Term Care

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

Ministère de la Santé et des Soins de longue durée

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

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

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

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Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2019	2019_655679_0001 (A1)	015166-18, 016510-18, 018003-18, 018465-18, 019843-18, 028519-18, 000380-19, 000496-19, 000663-19	Complaint

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

Amended by SHELLEY MURPHY (684) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

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

Request and approval granted for both compliance order date extensions.

Issued on this 14th day of February, 2019 (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

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

Ministère de la Santé et des Soins de longue durée

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

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Amended Inspection Summary/Résumé de l'inspection

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

This inspection was conducted on the following date(s): January 7-11 and 14-18, 2019.

The following intakes were inspected during this Complaint Inspection:

- Two intakes regarding medication administration and staffing;

- One intake regarding nail care and dealing with complaints;

- One intake regarding resident care concerns; and,

- Four intakes regarding resident falls and staffing.

A Critical Incident System intake(s) related to the same concerns was completed during this Complaint inspection.

A Critical Incident System (CIS) inspection #2019_655679_0002 was conducted concurrently with this inspection.

During the course of the inspection, the inspector(s) spoke with the Administrator, Director of Care (DOC), Assistant Directors of Care (ADOC), Physiotherapist, Restorative Care Manager, Scheduler, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Behavioural Supports Ontario (BSO) RPN, Resident Assessment Instrument (RAI) Coordinators, Personal Support Workers (PSWs), Restorative Care PSWs, Dietary Aids, Housekeepers, residents and their families.

The Inspectors also conducted a daily tour of resident care areas, observed the provision of care and services to residents, observed staff to resident interactions, reviewed relevant health care records, internal investigation notes, staff education records, complaint records, as well as relevant policies and procedures.

The following Inspection Protocols were used during this inspection:

Continence Care and Bowel Management
Falls Prevention
Medication
Nutrition and Hydration
Pain
Personal Support Services
Reporting and Complaints
Sufficient Staffing

During the course of the original inspection, Non-Compliances were issued.

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

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 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 nursing services for the home to meet the assessed needs of the residents.

A complaint was submitted to the Director for concerns regarding medication administration and staffing. The complaint identified that resident #015 did not receive their medications because there were no staff available to authorize the administration of the medication.

Inspector #679 reviewed the staffing calendar and identified that the home was short a number of RPNs on the shift that the incident occurred.

In an interview with Inspector #679, the DOC confirmed that the home was short staffed a specific number of RPNs on the shift in which the incident occurred.

Please see WN #2, finding #2 for details.

A) Inspector #679 reviewed a specific audit report for the date specified in the complaint. The report identified that there were a number of residents on the specified floor/wing. Out of the residents on the specified floor/wing the Inspector identified that greater than 65 per cent of residents were given their scheduled medications at least one hour after their prescribed administration time.

In an interview with RPN #110, they identified that they were the only RPN administering medications on the floor on the specified shift. RPN #110 identified that they worked short registered staff, almost every weekend that they worked, and that when this occurred residents were not getting their medications within the specified time frame, and that some of the residents received their medications two to three hours after the time they were supposed to get them. RPN #110 identified that when the home was working short registered staff, assessments weren't completed, and that residents may not get Pro Re Nata (PRN) or when required medications, when they should have.

B) Inspector #679 reviewed the staffing calendar for a specified month. The calendar identified that the home was short RPNs on the following occasions:

• Short two RPNs on a specified shift on the first date;
• Short one RPN on a specified shift on the second date;
• Short one RPN on a specified shift on the third date;
• Short one RPN on a specified shift, and two RPNs on a different shift on the fourth date;
• Short one RPN on a specified shift on the fifth date;
• Short one RPN on a specified shift on the sixth date;

• Short two RPNs on a specified shift, and one RPN on a different shift on the seventh date;
• Short two RPNs on a specified shift on the eighth date;
• Short one RPN on a specified shift on the ninth date;
• Short one RPN on a specified shift on the tenth date;
• Short one RPN on a specified shift on the eleventh date;
• Short one RPN on a specified shift on the twelfth date;
• Short one RPN on a specified shift on the thirteenth date; and,
• Short one RPN on a specified shift on the fourteenth date;

C) Inspector #679 reviewed the staffing calendar for a different month. The calendar identified that the home was short RPNs on the following occasions:

• Short two RPNs on a specified shift, and one RPN on a different shift on the first date;
• Short one RPN on a specified shift on the second date;
• Short one RPN on a specified shift on the third date;
• Short three RPNs on a specific shift, and one RPN on a different shift on the fourth date;
• Short three and a half RPNs on a specified shift, and one RPN on a different shift on the fifth date;
• Short one RPN on a specified shift on the sixth date; and,
• Short one RPN on a specified shift on the seventh date.

Inspector #679 reviewed the Staffing Plan for Extendicare Falconbridge which identified that each floor was to have two RPNs (totalling six RPNs) on the day and evening shift, and one RPN per floor (totalling three RPNs) on night shift.

Through a review of the staffing calendar, it was identified that the home worked short at least one RPN on 14 out of 31 days, or approximately 45 per cent of the time in the first month, and seven out of 13 days, or approximately 54 per cent of the time in the review period of the second month.

In an interview with RPN #127 they identified that they work short registered staff around two to four times per month, and that this mostly occurred on weekends. RPN #127 identified that when the home was short registered staff, they aren't able to give the residents one on one time, that they couldn't administer medications within the time frame, and that they do not have time to do specified assessments.

D) In an interview with RN #119 they identified that the home worked short staffed registered staff members very regularly. RN #119 identified that when the home was short registered staff specific resident focused tasks were affected.

Inspector #679 reviewed the Treatment Administration Record (TAR) for three specified floor/wings and identified that a number of treatments were not signed for on the specified date.

Together, Inspector #679 and RN #119 reviewed the treatment records identified above, and confirmed the missing documentation on each shift. RN #119 identified that it was usually the RNs who were responsible for completing the tasks outlined in the TAR, and that the blank documentation identified that the task wasn't completed.

In an interview with the DOC they identified that the RNs were responsible for completing the treatments in the TAR. Inspector #679 reviewed the missing documentation with the DOC; the DOC identified that the blank documentation would identify that the task was not completed without an explanation of why. The DOC identified that if the treatments were completed there should be documentation with the progress notes or PRN task. The DOC confirmed that the home was short one RN on the specified date, and that there were only three RPNs in the building. [s. 8. (1) (a)]

2. 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.

Complaints were submitted to the Director regarding staffing shortages in the home.

In a telephone interview with Inspector #679, the individual who submitted one of the complaints identified that the home was understaffed "all the time".

In an interview with Inspector #679, when asked if the residents felt the home had enough staff to ensure that they got the care and assistance they needed without having to wait a long time, the following residents answered "no" and shared the following:

- Resident #021 identified that the staffing was worse on the weekends, and that they had missed their bath or shower on a specific number of occasions due to short staffing;

- Resident #020 identified that they had missed their bath or shower due to short staffing;

- Resident #029 identified that when the home worked short staffed, their call bell was not answered promptly, and that sometimes they had to wait over 30 minutes for their call bell to be answered; and,

- Resident #015 identified that the home was so short that on a specified date they had not received their bath or shower. Resident #015 identified that this had occurred on a number of previous occasions.

A) A review of the "Staffing Plan for Extendicare Falconbridge" identified that the second and fourth floor staffed nine PSWs and the third floor staffed ten PSWs on day shift. On evening shift, the second and fourth floor staffed six PSWs for five and a half hours and three PSWs for seven and a half hours, while the third floor staffed seven PSWs for five and a half hours and three PSWs for seven and a half hours.

Inspector #687 reviewed the home's staffing levels over a three month period. The Inspector noted the following: the home utilized agency staff 55 per cent of the time in the first month. A review of the schedule for the second month identified that the home utilized agency staff to fill the short staffing 30 per cent of the month. The review for third month indicated that the home was short staffed 55 per cent of the month.

Inspector #679 reviewed the home's staffing levels between over a 44 day period (between the fourth and fifth month). The Inspector noted that the home worked short staffed in plan "c" or "d" 55 per cent of the time in the fourth month and 77 per cent of the time reviewed in the fifth month.

In an interview with Inspector #679, the DOC identified that plan "b" meant the floor was short one PSW from their regular staffing complement; plan "c" indicated that the floor was short two PSWs from their regular staffing complement, and, that plan "d" indicated that the floor was short three PSWs from their regular staffing complement.

B) The Inspector reviewed three selected dates from the specific month in which the home worked short staffed, to determine if the residents received their scheduled bath/shower.

i) On a specified date, specific floors worked plan "c", while other floors worked plan "c" and plan "d".

The Inspector reviewed a specific report for the home and identified that on the specified date, a number of residents baths/showers were marked as either "Not Applicable" or "Activity Did Not Occur".

Inspector #679 reviewed a different report for a specified month which confirmed that the resident's baths/showers were marked either as "Not Applicable" or as "Activity Did Not Occur". The Inspector then reviewed the progress notes which did not identify any indication that the missed baths were completed.

ii) On a separate date, specific floors worked plan "c", while other floors worked plan "d".

The Inspector reviewed a specific report for bathing for the home and identified that on the specified date, resident #001's scheduled bath/shower was documented as "Activity Did Not Occur".

Inspector #679 reviewed a specific report for a specified month which identified that resident #001 was to receive their scheduled bath/shower on specified dates. The Inspector noted the resident received their prior shower on a specified date, and their next shower, a number of days later. The Inspector then reviewed the progress notes and did not identify notes which indicated that this resident's bath/shower was completed.

During separate interviews with PSW #141, #142, #109 and #143, they identified that the home worked short staffed very often.

C) In an interview with Inspector #679, PSW #143 identified that when the home worked short staffed resident's baths or showers were sometimes missed. PSW #143 identified that if the record was documented as "not applicable" or "activity did not occur", the resident's bath/shower was not completed. PSW #143 identified that a specific number of weeks ago, resident #022 did not receive their

bath/shower because of short staffing.

Inspector #679 reviewed resident #022's documentation record which identified that, on the date identified by PSW #143, the resident's bath/shower was documented as not applicable. The resident's next completed bath was documented on the resident's next scheduled bath date.

The Inspector then reviewed the progress notes which did not identify any indication that the bath/shower was completed.

During an interview with RPN #127, they identified that the home was rarely fully staffed. RPN #128 identified that when the home was short staffed the residents did not get extra personal time, and that everyone was rushed. RPN #127 identified that 95 per cent of the time the baths or showers were completed.

In an interview with RN #119 they identified that the home worked short staffed most of the time. RN #119 identified that when the home was short PSWs it was difficult for them to be able to complete baths/showers, be on time for meal services and complete care as thoroughly as they would like to.

In an interview with the DOC, Inspector #679 reviewed the reports outlining the missed baths/showers. The DOC identified that the home attempts to replace sick calls by posting internally and externally. [s. 8. (1) (b)]

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. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

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

Findings/Faits saillants :

1. The licensee has failed to ensure that no drug was used by or administered to a resident in the home unless the drug had been prescribed for the resident.

A complaint report was submitted to the Director regarding a medication incident. The complaint identified that ADOC #132 had provided an incorrect medication to resident #002.

Inspector #687 reviewed resident #002's electronic Medication Administration Record (eMAR), which indicated that the resident was to receive a specified medication (different from what the resident received).

Inspector #687 reviewed the home's policy titled "Medication Management" last revised February 2018, which indicated that the "MAR/eMAR paper or electronic format was to be used to document all medications given to a resident. The policy further indicated that the nurse administered medications following the "8 Rights" as follows: right resident, right drug, right dose, right time, right route, right reason, right response and right documentation.

In an interview conducted by Inspector #687 with RPN #151, they stated that prior to administering a medication to a resident, the registered staff must ensure to follow the "8 Rights" as per the home's policy.

In an interview with the ADOC #132, they stated that on a specified date they gave the incorrect medication to resident #002. The ADOC stated that they were

distracted and that they did not follow the "8 Rights" of the home's policy for Medication Management.

In an interview with the ADOC #138, they stated that in their internal investigation, it indicated that ADOC #132 was distracted and that they did not read the medication order correctly for resident #002 in the eMAR. ADOC #138 identified that ADOC #132 administered the incorrect medication to resident #002. [s. 131. (1)]

2. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A CI report and a complaint were submitted to the Director for a medication incident. The CI report identified that resident #015 had not received their scheduled medications on time.

Inspector #679 reviewed the "Physician's Orders Audit Report" which identified that residents #015, #017 and #018 all received their medications more than one hour after the prescribed time.

In an interview with resident #015 they identified that they hadn't gotten their medications on time on the date of the incident.

In an interview with RPN #110 they identified that on the day of the incident they were doing the medication pass for the entire unit. RPN #110 confirmed that resident #015 had not received their medications on time. RPN #110 identified that staff typically have an hour before and an hour after to administer the scheduled medications.

In an interview with the DOC they identified that were unable to find the actual or specified time that staff have before or after the prescribed time to administer the medications in a policy. The DOC confirmed that it was the expectation that the resident received their medications at the prescribed time. [s. 131. (2)]

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

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 ensuring that no drug is used or administered to a resident in the home unless the drug has been prescribed for the resident, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

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

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).

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

Findings/Faits saillants :

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

A complaint was submitted to the Director regarding specific care concerns for resident #005.

Inspector #679 reviewed resident #005's current electronic care plan and identified that staff were to ensure that a specific intervention was in a specified location for resident #005 to use.

Inspector #679 observed resident #005 on a specified date. The Inspector did not observe the intervention in the specified location, for resident #005.

In an interview with PSW #118, they identified that resident #005 was at a particular level of risk for a falls. Together, Inspector #679 and PSW #118 went to observe resident #005. PSW #118 located the specific intervention and placed it within reach of the resident. PSW #118 confirmed that the intervention was to be in reach of the resident.

A review of the policy entitled "Care Planning" last updated April 2017, identified that the care plan was a guide that directed care that was to be provided to the resident.

In an interview with RN #112, they identified that resident #005 was at a specified level of risk for falls. RN #112 identified that there were interventions in place to prevent and manage the risk of falls, including the use of a specified intervention. RN #112 identified that resident #005 would use the intervention if it was in a specified location.

In an interview with the DOC they identified that staff reference a resident's care plan to identify their care needs. Together, the Inspector and DOC reviewed the care plan. When asked if it was the expectation that staff following the care outlined in the plan of care the DOC answered "if that was what it said". [s. 6. (7)]

2. A complaint was submitted to the Director outlining resident #003's fall incidents that occurred over a specified amount of time.

Inspector #687 conducted a review of resident #003's fall incidents, and identified

that the resident had fallen on a number of dates. Through the record review it was identified that for each of the fall incidents resident #003 had attempted a specified action.

Inspector #687 reviewed resident #003's care plan which indicated that staff were to ensure that specified interventions were in place. The care plan further indicated that staff were to assist resident #003 when they were performing a specified action.

Multiple observations were conducted in a specific home area; during the observation, resident #003 made multiple attempts to perform the action, but there were no staff to assist them.

On specific dates, Inspector #687 observed resident #003 perform the specified action with no staff assistance.

During an interview with PSW #150 and #134, they stated that resident #003 required staff assistance to perform a specified action.

During an interview with RPN #121, they stated that resident #003 required staff assistance to perform a specified action.

In an interview with ADOC #132, they stated that resident #003 required assistance from staff to perform a specified action. The ADOC further stated that the staff should have followed the direction in the plan of care, and assisted the resident in performing the specific action. [s. 6. (7)]

3. A CI report was submitted to the Director related to a fall of resident #012 resulting in an injury.

Inspector #744 reviewed resident #012's current care plan and identified that staff were to ensure that resident #001 had a specified intervention in place.

On a specific date, Inspector #744 observed resident #012 without the intervention in place. The observation was confirmed by PSW #113.

In an interview with the Inspector, PSW #114 stated that according to resident #012's care plan, they were to have a specified intervention in place.

In an interview with Inspector #744, ADOC #131 stated that staff should follow the interventions listed in the residents care plan. ADOC #131 confirmed that the specified intervention for resident #012 should have been in place at a specific time. [s. 6. (7)]

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

A CI report was submitted to the Director related to the fall of resident #012 resulting in an injury.

Inspector #744 reviewed resident #012's care plan at the time of the incident, which indicated that resident #012 was supposed to receive assistance with a specified type of care a specific number of times per day.

Inspector #744 reviewed a care record for resident #012, which displayed documented times of when the specified care had been completed for the resident. Inspector #744 observed that the care was only documented approximately 43 per cent of the time, out of specified number of times required in the resident's care plan.

In an interview with Inspector #744, PSW #144 stated that the care was to be provided to the resident at a specified interval.

In an interview with Inspector #744, ADOC #131 stated that care must be documented by staff at the time the care was provided. ADOC #131 confirmed that staff did not document all the care being provided for a specified amount of time before the incident involving resident #012. [s. 6. (9) 1.]

5. A complaint was submitted in relation to staff not implementing a specified intervention for resident #003.

Inspector #687 conducted a review of the resident's electronic record and identified that the resident had an order for a specified intervention.

Inspector #687 reviewed resident #003's progress notes and identified a note written by RN #119. The progress note indicated that the registered staff had been implementing the specified intervention.

Inspector #687 reviewed the home's policy last revised February 2017, which indicated that a specific record was to be used to document all interventions given to a resident.

In an interview with PSW #109, they stated that the resident had specific symptoms and that the registered staff provided interventions to manage the specific symptoms.

In an interview with RPN #154 and #156, they stated that they had used the specified intervention for resident #003 for their specific symptoms but were unable to provide the dates of when this was completed.

In an interview with RN #119, they verified that they documented in the resident's electronic progress notes. The RN further stated that RPN #152 reported that they had used the specified intervention for resident #003 due to specific symptoms.

In an interview conducted by Inspector #687 with ADOC #138, they verified that the specified record did not indicate any documentation that the intervention was used for resident #003. The Inspector and the ADOC also looked at the progress notes of resident #003, which indicated that the intervention was used for the specific symptoms but had not been documented. The ADOC further stated that the staff should have had documented that the intervention was used according to the specific policy.

6. A CI report was submitted to the Director related to a fall of resident #012 resulting in an injury.

Inspector #744 reviewed resident #012's electronic record and identified that a specified assessment was not completed at the specified interval after the fall.

A review of the policy entitled "Falls Prevention and Management Program" last revised February, 2017, identified under "post fall management" that staff were to complete a specified assessment under certain circumstances.

In an interview with Inspector #744, RPN #107 stated that they responded to resident #012's fall. RPN #107 stated that staff were to complete a specified assessment under certain circumstances.

In an interview with Inspector #744, ADOC #131 stated that a specified

assessment must be conducted at specified intervals under certain circumstances. ADOC #131 confirmed that the specified assessment should have been completed at specified intervals after a fall. [s. 6. (9) 1.]

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

A CI report was submitted to the Director. According to the CI report, resident #011 demonstrated specific responsive behaviours and performed a specific action towards resident #010.

Inspector #684 reviewed resident #011's current care plan and noted that the care plan stated that resident #011 required a specified level of assistance by a number of staff members for different aspects of care.

Inspector #684 interviewed PSW #126 regarding the number of staff required to provide care to resident #011; PSW #126 stated that they provided care to resident #011 with the assistance of a specified number of staff. During a separate interview with PSW #123, they stated that resident #011 required a specified number of staff for different aspects of care.

In an interview with Inspector #684, RPN #110 confirmed that resident #011 required a specified number of staff members for care when being assisted with different aspects of care.

Inspector #684 conducted an interview with RN #125, who stated that resident #011 required a specified number of staff for care, and that they had always seen a specified number of staff provide specific care to resident #011. Inspector #684 reviewed the current care plan for resident #011 with RN #125, and the RN agreed that the current care plan in place did not match the care that was being provided to resident #011.

Inspector #684 reviewed the home's policy for Responsive Behaviours (RC-17-01 -04), last updated February 2017. Under the "Procedure" section it stated: Ensure that the care plan contained information related to each behaviour observed and included at a minimum: ways to complete a task or ADL that minimized the likelihood of the behaviour appearing.

Inspector #684 reviewed the home's policy titled "Care Planning (RC-05-01-01)", last updated April 2017, which identified under the "Procedure" section that staff were to "review, evaluate and revise the effectiveness of the interventions outlined in the care plan on a quarterly basis, at minimum, following admission, whenever there was a change in the resident's condition, and after completion of each new MDS assessment".

Inspector #684 interviewed ADOC #138 regarding resident #011's current care plan, with regards to how many staff were required to provide care. ADOC #138 reviewed the care plan for resident #011 and confirmed that resident #011 did require a specified number of staff for care and that the care plan that was in place was not reflective of the care being provided and needed to be updated. [s. 6. (10) (b)]

8. Three CI reports were submitted to the Director regarding resident #012's responsive behaviours.

Inspector #687 reviewed resident #002's current electronic care plan which indicated that resident #012 had a focus for a specified behaviour.

In an interview with PSW #146 and RPN #107, they stated that resident #012 no longer exhibited the specific responsive behaviour.

Under the heading of, "Care Planning Procedures" the home's "Care Planning" policy (updated April 2017), directed staff to ensure that the care plan was revised when appropriate to reflect the resident's current needs based on evaluation of significant changes in the resident's status.

In an interview with ADOC #131, they stated that resident #012 no longer exhibited the specified responsive behaviour. The ADOC acknowledged that the care plan indicated that resident #012 would exhibit the specified responsive behaviour which had now changed. The ADOC further indicated that the care plan should have been updated to reflect the resident's change in care needs. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the care set out in the plan of care is provided to the resident as specified in the plan; that the plan of care is reviewed and revised at least every six months and at any other time when, the resident's care needs change or care set out in the plan was no longer necessary, and that the provision of care set out in the plan of care is documented, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

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

Findings/Faits saillants :

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

In accordance with Ontario Regulation 79/10, s 49. (1), the licensee was required to ensure that the falls prevention and management program must, at a minimum provide for strategies to reduce or mitigate falls, including the monitoring of residents, the review of residents' drug regimes, the implementation of restorative approaches and the use of equipment, supplies, devices and assistive aids.

Specifically, staff did not comply with the licensee's policy regarding "Falls

Prevention and Management Program" with a review date of February, 2017, which was part of the home's falls prevention and management program.

A Complaint was submitted to the Director regarding care concerns for resident #005.

Inspector #679 reviewed the electronic progress notes and identified that the resident sustained a fall on a specified date. A further review of the progress notes identified that RPN #104 documented that the previous RPN did not initiate a specified assessment.

Inspector #679 reviewed the electronic record and did not identify that the assessment was initiated immediately after the fall.

A review of the policy entitled "Falls Prevention and Management Program" last revised February, 2017, identified under "post fall management" that staff were to complete a specified assessment under certain circumstances.

In an interview with RPN #127 they identified that the specified assessment would be initiated under certain circumstances. Together, Inspector #679 and RPN #127 reviewed the progress notes. RPN #127 identified that the next shift had initiated specified assessment for resident #005, and that it was to be initiated after the fall.

In an interview with the DOC, they identified that the specified assessment would be initiated under certain circumstances. Together, Inspector #679 and the DOC reviewed the residents progress notes. The DOC confirmed that it was the expectation that the staff would start the assessment immediately after the fall.

2. In accordance with Ontario Regulation 79/10, s.136.(1), the licensee was to ensure that as part of the medication management system, a written policy was developed to ensure that drugs were destroyed and disposed of in a safe and environmentally appropriate manner in accordance with evidence-based practices and, if there were none, in accordance with prevailing practices.

Specifically, staff did not comply with the licensee's policy regarding Monitored Medications: Disposal for Monitored Medications, with a review date of July, 2017, which was a part of the licensee's medication management program.

A CI report was submitted to the Director for a missing medication for which it was identified that there was a missing co-signature for the waste of the medication. The CI report identified that the incident had occurred on a specified date, and was discovered a number of days later. A review of the CI report by Inspector #679 identified that RPN #104 indicated that they were unaware of the need to place the medication in a specified location, and that they disposed of the medication elsewhere.

Inspector #679 reviewed a specific medication record for resident #008's medication, and identified that on a specified date, the section titled "wasted" was blank.

A review of the policy entitled Monitored Medications: Disposal for Monitored Medications with a review date of July, 2017, identified that the nurse was to remove the specified medications and place it in a specified manner in a specific location until the nurse has completed the medication pass, and that at the end of the shift, once all the medications had been removed and documented, there would be a reconciliation of the number of the medications by a second nurse.

In an interview with RPN #104, they identified that they believed that they threw the medication away. RPN #104 identified that the process of administering, and disposing of the medication required two nursing staff, and a specific process. RPN #104 acknowledged that they did not follow the protocol, as they weren't aware of what the protocol was at the time of the incident.

In an interview with DOC they described the process for when a medication was being disposed of. The DOC identified that in this incident, the RPN had thrown the medication away, and that the home's process was not followed. The DOC further identified that the error was noted by another staff member, and that the staff members who had completed the count missed the missing documentation. [s. 8. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that the home's policies titled Falls Prevention and Management Program and Disposal for Monitored Medications are complied with, to be implemented voluntarily.

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

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

Findings/Faits saillants :

1. The licensee has failed to ensure that each resident of the home was 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.

A complaint was submitted to the Director, which identified that the home often worked short staffed.

Please see WN #1, finding #2 for details.

Inspector #679 reviewed three selected dates from a specific month, in which the home worked short staffed.

The Inspector reviewed a specific report for bathing for the home and identified that on a specified date, a number of resident baths/showers were marked as either "Not Applicable" or "Activity Did Not Occur".

The Inspector reviewed a specific report for bathing for the home and identified that on a different date, resident #001's scheduled bath/shower was documented as "activity did not occur".

Inspector #679 reviewed the health care records and noted that the aforementioned residents did not have their scheduled baths/showers made up prior to the next scheduled bath/shower.

In an interview with Inspector #679, PSW #143 identified that when the home worked short staffed resident's baths or showers were sometimes missed. PSW #143 identified that if the charting was documented as "not applicable" or "activity did not occur" that the resident's bath wasn't completed.

A review of the home's policy titled "Bathing, Showering and Water Temperature Monitoring - RC-06-01-02" 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 the DOC they identified that residents were offered two baths/showers per week. Together with the DOC, the Inspector reviewed the specific report for the missed baths/showers. The DOC identified that the baths/showers would be documented in a specific record, and that if the baths/showers were missed and then made up it would be documented in the record or in progress notes. The DOC confirmed that if a resident missed their bath/shower, the bath/shower was to be made up the next shift. [s. 33. (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 ensuring 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, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that every resident had the right to have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act.

A Complaint was submitted to the Director regarding specific resident care concerns.

A review of the progress notes identified that on a specified date, a specific individual received personal health information about resident #005.

Inspector #679 reviewed resident #005's paper chart, and identified that the individual who had received the personal health information was not the resident's Substitute Decision Maker (SDM).

In an interview with RPN #127, they identified that a staff member had provided specified information about resident #005 to a specific individual who was not the resident's SDM.

In an interview with ADOC #132 they identified that resident #005's SDM was the individual who could receive personal health information regarding resident #005. ADOC #132 identified that staff were to check the resident's chart or electronic profile to determine who can receive this type of information.

In an interview with the DOC, they identified that RN #140 had provided resident #005's personal health information to a specific individual who was not the resident's SDM. The DOC identified that it was very clear in the resident profile and chart who was to receive resident specific information. The DOC identified that the individual who received the specified information was not to receive personal health information, related to resident #005.

WN #7: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that all staff who provide direct care to residents, received training relating to abuse recognition and prevention, annually, or as determined by the licensee, based on the assessed training needs of the individual staff member.

According to r. 221 (2) of the Ontario Regulation 79/10 staff must receive annual training in all the areas required under subsection 76 (7).

A CI report was submitted to the Director on a specified date, which outlined allegations of physical abuse by PSW #139 to resident #001. The CI report identified that the incident was witnessed by PSW #124 a specified amount of time prior to when it was reported to the DOC.

Inspector #744 reviewed the education record titled "Zero Tolerance for Abuse and Neglect ALL STAFF" for 2018, which identified that there were 13 staff members who did not complete their abuse education for 2018.

A review of the policy entitled "Zero Tolerance of Resident Abuse and Neglect Program" last revised April 2017, identified that training during orientation and annual retraining thereafter was required.

In an interview with Inspector #744, the DOC stated that it was required that all staff members be trained on zero tolerance for abuse and neglect annually. After reviewing the "Zero Tolerance for Abuse and Neglect ALL STAFF" education record for 2018, with the DOC, they identified that 13 staff members should have received annual training in 2018. [s. 76. (7) 1.]

2. The licensee has failed to ensure that all direct staff were provided training in falls prevention and management.

According to r. 221 (1) of the Ontario Regulation 79/10 the following were other areas in which training shall be provided to all staff who provide direct care to residents: falls prevention and management.

According to r. 221 (2) of the Ontario Regulation 79/10 staff must receive annual training in all the areas required under subsection 76 (7).

A Critical Incident (CI) report and complaints were submitted to the Director regarding residents sustaining falls.

Inspector #679 requested a copy of the home's training records for fall prevention for 2018, and was provided with a Document titled "Course Completions" for January 1 to December 31, 2018. The course record identified under "Falconbridge Nursing" that nine per cent of staff had not completed the education for 2018.

A review of the policy entitled "Falls Prevention and Management Program" last revised February 2017 identified for the home to "educate staff, resident's families/SDMs and other relevant persons on fall and injury prevention and relevant falls and safe lifting with care program components".

In an interview with the DOC they confirmed the numbers identified on the report. The DOC identified that the home's education year was January to December, and that it was the home's expectation that all staff completed their falls education annually. [s. 76. (7) 6.]

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

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

Findings/Faits saillants :

1. The licensee has failed to ensure that drugs were stored in an area or a medication cart that was secured and locked.

A) On a specific date, Inspector #687 observed a medication cart left unlocked and unattended in front of the medication room on a specified home area for 17 minutes. The medication cart was observed to contain a number of prescribed medications in the drawers. RN #112 was not in sight of the cart at the time of the observation.

During the time the medication cart was left unattended, numerous residents were within the immediate vicinity of the medication cart as they were passing by to go to the dining room.

B) On a different date, Inspector #687 observed a medication cart unlocked and unattended in front of a specified room for approximately three minutes. RPN #104 was administering medications to residents in their rooms and was not in sight of the cart.

In a review of the home's policy titled "Medication Management" last updated February 2018, it indicated under medication administration the following: ensure the medication cart was locked when unattended or out of sight.

During an interview with Inspector #687, RN #112 and RPN #104 stated that the medication cart was supposed to be locked at all times whenever they were away from the cart.

Inspector #687 interviewed the DOC, who stated that the medication cart should have been locked any time registered staff were not in attendance of the cart, to prevent harm or risk of harm to any resident. [s. 129. (1) (a)]

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes
Every licensee of a long-term care home shall ensure that,
(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;
(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and
(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee has failed to ensure that for a resident taking any drug or combination of drugs that there was monitoring and documentation of the resident's response and the effectiveness of the drugs.

A complaint was submitted to the Director in relation to resident #003's specific symptoms.

Inspector #687 reviewed resident #003's progress notes, and identified that on a specified date, the resident was given a specific medication. The Inspector did not identify any documentation to indicate that the intervention provided was effective.

Inspector #687 reviewed the home's policy which indicated that nurses assess a residents symptoms using a specific assessment.

In a review of resident #003's electronic record for a specified month, it was identified that resident #003 received the specified medication on a specified date.

In an interview with PSW #109, they stated that resident #003 had specific symptoms and that registered staff provided specific interventions to manage the specific symptoms.

In an interview with RPN #127, they stated that the registered staff should have completed the assessment to monitor the symptoms on the specified date.

During an interview with the ADOC #138, they verified that resident #003 was given a specific medication on a specified date, and further verified that registered staff should have had completed a specific assessment according to the home's policy, but they did not. [s. 134. (a)]

Issued on this 14th day of February, 2019 (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
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by SHELLEY MURPHY (684) - (A1)
Inspection No. / No de l'inspection :	2019_655679_0001 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	015166-18, 016510-18, 018003-18, 018465-18, 019843-18, 028519-18, 000380-19, 000496-19, 000663-19 (A1)
Type of Inspection / Genre d'inspection :	Complaint
Report Date(s) / Date(s) du Rapport :	Feb 14, 2019(A1)
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Falconbridge 281 Falconbridge Road, SUDBURY, ON, P3A-5K4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Laura Halloran

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 Extendicare (Canada) Inc., 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) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, 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

(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).

Order / Ordre :

The licensee must be complaint with s. 8. (1) (a) and (b) of the Long Term Care Homes Act.

The licensee shall prepare, submit and implement a plan to ensure that there is an organized program of nursing and personal support services for the home to meet the assessed needs of the residents.

The plan must include, but is not limited to the following:

a) how the licensee will ensure that there is an organized program of nursing services for the home to meet the assessed needs of the residents; specifically ensuring that medications and treatments are administered within their prescribed time frame; and,

b) how the licensee will ensure that there is an organized program of personal support services for the home to meet the assessed needs of the residents; specifically ensuring that residents receive their baths as outlined in the residents plan of care.

The plan must be emailed to the attention of LTCH Inspector Michelle Berardi. The plan is due on February 19, 2019, and the order is to be complied by March 19, 2019.

Please ensure that the submitted written plan does not contain any Personal Information and/or Personal Health Information.

Grounds / Motifs :

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

A complaint was submitted to the Director for concerns regarding medication administration and staffing. The complaint identified that resident #015 did not receive their medications because there were no staff available to authorize the administration of the medication.

Inspector #679 reviewed the staffing calendar and identified that the home was short a number of RPNs on the shift that the incident occurred.

In an interview with Inspector #679, the DOC confirmed that the home was short staffed a specific number of RPNs on the shift in which the incident occurred.

Please see WN #2, finding #2 for details.

A) Inspector #679 reviewed a specific audit report for the date specified in the complaint. The report identified that there were a number of residents on the specified floor/wing. Out of the residents on the specified floor/wing the Inspector identified that greater than 65 per cent of residents were given their scheduled medications at least one hour after their prescribed administration time.

In an interview with RPN #110, they identified that they were the only RPN administering medications on the floor on the specified shift. RPN #110 identified that they worked short registered staff, almost every weekend that they worked, and that when this occurred residents were not getting their medications within the specified time frame, and that some of the residents received their medications two to three hours after the time they were supposed to get them. RPN #110 identified that when the home was working short registered staff, assessments weren't completed, and that residents may not get Pro Re Nata (PRN) or when required medications, when they should have.

B) Inspector #679 reviewed the staffing calendar for a specified month. The calendar identified that the home was short RPNs on the following occasions:

• Short two RPNs on a specified shift on the first date;
• Short one RPN on a specified shift on the second date;
• Short one RPN on a specified shift on the third date;
• Short one RPN on a specified shift, and two RPNs on a different shift on the fourth date;
• Short one RPN on a specified shift on the fifth date;
• Short one RPN on a specified shift on the sixth date;
• Short two RPNs on a specified shift, and one RPN on a different shift on the seventh date;
• Short two RPNs on a specified shift on the eighth date;
• Short one RPN on a specified shift on the ninth date;
• Short one RPN on a specified shift on the tenth date;

• Short one RPN on a specified shift on the eleventh date;
• Short one RPN on a specified shift on the twelfth date;
• Short one RPN on a specified shift on the thirteenth date; and,
• Short one RPN on a specified shift on the fourteenth date;

C) Inspector #679 reviewed the staffing calendar for a different month. The calendar identified that the home was short RPNs on the following occasions:

• Short two RPNs on a specified shift, and one RPN on a different shift on the first date;
• Short one RPN on a specified shift on the second date;
• Short one RPN on a specified shift on the third date;
• Short three RPNs on a specific shift, and one RPN on a different shift on the fourth date;
• Short three and a half RPNs on a specified shift, and one RPN on a different shift on the fifth date;
• Short one RPN on a specified shift on the sixth date; and,
• Short one RPN on a specified shift on the seventh date.

Inspector #679 reviewed the Staffing Plan for Extendicare Falconbridge which identified that each floor was to have two RPNs (totalling six RPNs) on the day and evening shift, and one RPN per floor (totalling three RPNs) on night shift.

Through a review of the staffing calendar, it was identified that the home worked short at least one RPN on 14 out of 31 days, or approximately 45 per cent of the time in the first month, and seven out of 13 days, or approximately 54 per cent of the time in the review period of the second month.

In an interview with RPN #127 they identified that they work short registered staff around two to four times per month, and that this mostly occurred on weekends. RPN #127 identified that when the home was short registered staff, they aren't able to give the residents one on one time, that they couldn't administer medications within the time frame, and that they do not have time to do specified assessments.

D) In an interview with RN #119 they identified that the home worked short staffed registered staff members very regularly. RN #119 identified that when the home was short registered staff specific resident focused tasks were affected.

Inspector #679 reviewed the Treatment Administration Record (TAR) for three specified floor/wings and identified that a number of treatments were not signed for on the specified date.

Together, Inspector #679 and RN #119 reviewed the treatment records identified above, and confirmed the missing documentation on each shift. RN #119 identified that it was usually the RNs who were responsible for completing the tasks outlined in the TAR, and that the blank documentation identified that the task wasn't completed.

In an interview with the DOC they identified that the RNs were responsible for completing the treatments in the TAR. Inspector #679 reviewed the missing documentation with the DOC; the DOC identified that the blank documentation would identify that the task was not completed without an explanation of why. The DOC identified that if the treatments were completed there should be documentation with the progress notes or PRN task. The DOC confirmed that the home was short one RN on the specified date, and that there were only three RPNs in the building. (679)

2. 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.

Complaints were submitted to the Director regarding staffing shortages in the home.

In a telephone interview with Inspector #679, the individual who submitted one of the complaints identified that the home was understaffed "all the time".

In an interview with Inspector #679, when asked if the residents felt the home had enough staff to ensure that they got the care and assistance they needed without having to wait a long time, the following residents answered "no" and shared the following:

- Resident #021 identified that the staffing was worse on the weekends, and that they had missed their bath or shower on a specific number of occasions due to short staffing;

- Resident #020 identified that they had missed their bath or shower due to short staffing;

- Resident #029 identified that when the home worked short staffed, their call bell was not answered promptly, and that sometimes they had to wait over 30 minutes for their call bell to be answered; and,

- Resident #015 identified that the home was so short that on a specified date they had not received their bath or shower. Resident #015 identified that this had occurred on a number of previous occasions.

A) A review of the "Staffing Plan for Extendicare Falconbridge" identified that the second and fourth floor staffed nine PSWs and the third floor staffed ten PSWs on day shift. On evening shift, the second and fourth floor staffed six PSWs for five and a half hours and three PSWs for seven and a half hours, while the third floor staffed seven PSWs for five and a half hours and three PSWs for seven and a half hours.

Inspector #687 reviewed the home's staffing levels over a three month period. The Inspector noted the following: the home utilized agency staff 55 per cent of the time in the first month. A review of the schedule for the second month identified that the home utilized agency staff to fill the short staffing 30 per cent of the month. The review for third month indicated that the home was short staffed 55 per cent of the month.

Inspector #679 reviewed the home's staffing levels between over a 44 day period (between the fourth and fifth month). The Inspector noted that the home worked short staffed in plan "c" or "d" 55 per cent of the time in the fourth month and 77 per cent of the time reviewed in the fifth month.

In an interview with Inspector #679, the DOC identified that plan "b" meant the floor was short one PSW from their regular staffing complement; plan "c" indicated that the floor was short two PSWs from their regular staffing complement, and, that plan "d" indicated that the floor was short three PSWs from their regular staffing complement.

B) The Inspector reviewed three selected dates from the specific month in which the home worked short staffed, to determine if the residents received their scheduled bath/shower.

i) On a specified date, specific floors worked plan "c", while other floors worked plan "c" and plan "d".

The Inspector reviewed a specific report for the home and identified that on the specified date, a number of residents baths/showers were marked as either "Not Applicable" or "Activity Did Not Occur".

Inspector #679 reviewed a different report for a specified month which confirmed that the resident's baths/showers were marked either as "Not Applicable" or as "Activity Did Not Occur". The Inspector then reviewed the progress notes which did not identify any indication that the missed baths were completed.

ii) On a separate date, specific floors worked plan "c", while other floors worked plan "d".

The Inspector reviewed a specific report for bathing for the home and identified that on the specified date, resident #001's scheduled bath/shower was documented as "Activity Did Not Occur".

Inspector #679 reviewed a specific report for a specified month which identified that resident #001 was to receive their scheduled bath/shower on specified dates. The Inspector noted the resident received their prior shower on a specified date, and their next shower, a number of days later. The Inspector then reviewed the progress notes and did not identify notes which indicated that this resident's bath/shower was completed.

During separate interviews with PSW #141, #142, #109 and #143, they identified that the home worked short staffed very often.

C) In an interview with Inspector #679, PSW #143 identified that when the home worked short staffed resident's baths or showers were sometimes missed. PSW #143 identified that if the record was documented as "not applicable" or "activity did not occur", the resident's bath/shower was not completed. PSW #143 identified that a specific number of weeks ago, resident #022 did not receive their bath/shower because of short staffing.

Inspector #679 reviewed resident #022's documentation record which identified that, on the date identified by PSW #143, the resident's bath/shower was documented as not applicable. The resident's next completed bath was documented on the resident's

next scheduled bath date.

The Inspector then reviewed the progress notes which did not identify any indication that the bath/shower was completed.

During an interview with RPN #127, they identified that the home was rarely fully staffed. RPN #128 identified that when the home was short staffed the residents did not get extra personal time, and that everyone was rushed. RPN #127 identified that 95 per cent of the time the baths or showers were completed.

In an interview with RN #119 they identified that the home worked short staffed most of the time. RN #119 identified that when the home was short PSWs it was difficult for them to be able to complete baths/showers, be on time for meal services and complete care as thoroughly as they would like to.

In an interview with the DOC, Inspector #679 reviewed the reports outlining the missed baths/showers. The DOC identified that the home attempts to replace sick calls by posting internally and externally.

The severity of this issue was determined to be a level two, as there was minimal harm or potential for actual harm to the residents of the home. The scope of the issue was a level two, pattern. The home had a level three compliance history, with the following non-compliance with this section of the LTCHA that included:

- A Voluntary Plan of Correction (VPC) issued June 28, 2018, during inspection #2018_671684_0013; and,

- A VPC issued February 16, 2017, during inspection #2016_264609_0029.
(679)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 31, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 002

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

Pursuant to / Aux termes de :

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

Order / Ordre :

The licensee must be compliant with r. 131. (2) of the Ontario Regulation 79/10.

The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber.

Grounds / Motifs :

1. The licensee has failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

A CI report and a complaint were submitted to the Director for a medication incident. The CI report identified that resident #015 had not received their scheduled medications on time.

Inspector #679 reviewed the "Physician's Orders Audit Report" which identified that residents #015, #017 and #018 all received their medications more than one hour after the prescribed time.

In an interview with resident #015 they identified that they hadn't gotten their medications on time on the date of the incident.

In an interview with RPN #110 they identified that on the day of the incident they were doing the medication pass for the entire unit. RPN #110 confirmed that resident #015 had not received their medications on time. RPN #110 identified that staff typically have an hour before and an hour after to administer the scheduled medications.

In an interview with the DOC they identified that were unable to find the actual or specified time that staff have before or after the prescribed time to administer the medications in a policy. The DOC confirmed that it was the expectation that the resident received their medications at the prescribed time.

The severity of this issue was determined to be a level two, as there was minimal harm or potential for actual harm to the residents of the home. The scope of the issue was a level three, widespread, as it related to three of three residents reviewed. The home had a level three compliance history, with the following non-compliance with this section of the LTCHA that included:

- A Voluntary Plan of Correction (VPC) issued September 21, 2017, during inspection #2017_463616_0009; and,

- A Compliance Order (CO) issued November 7, 2017, during inspection #2017_633577_0018. (679)

Ontario

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Ministère de la Santé et des Soins de longue durée

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Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Mar 11, 2019(A1)

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:

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Health Services Appeal and Review Board and the Director

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

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

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

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

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

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

La demande écrite doit comporter ce qui suit :

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

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

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

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

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

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

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

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

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

Issued on this 14th day of February, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by SHELLEY MURPHY (684) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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