Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

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

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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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Nov 1, 2019	2019_669642_0019	016158-19, 016590-19, 016660-19	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 Tri-Town
143 Bruce Street P.O. Box 999 HAILEYBURY ON P0J 1K0

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

AMY GEAUVREAU (642)

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): September 30, October 1-4, 2019.

Three complaints: were submitted to the Director related to insufficient staffing and resident care concerns were inspected.

During the course of the inspection, the inspector(s) spoke with Administrator/Director of Care (DOC), Office Manager/Scheduler, Resident Assessment Instrument (RAI) Coordinator, Nursing Clerk, Registered Nurses (RNs), Registered Practical Nurses (RPNs), Personal Support Workers (PSWs), residents and resident family members.

The Inspector also conducted daily tours of the resident care areas, reviewed resident care records, staff schedules, procedures and programs and observed resident rooms, resident common areas, and the delivery of resident care and services, including resident to staff interactions.

The following Inspection Protocols were used during this inspection:
Personal Support Services
Sufficient Staffing

During the course of this inspection, Non-Compliances were issued.
- **3 WN(s)**
- **1 VPC(s)**
- **3 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).

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

Findings/Faits saillants :

1. The licensee 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.

Three complaints had been submitted to the Director which outlined concerns related to the shortage of staff and how it was affecting the care of residents in the home.

A) Inspector #642 interviewed Resident Assessment Instrument (RAI) Coordinator #102, who identified the normal staffing level for the home of 60 residents with two units. The home had three Personal Support Workers (PSWs) for each unit, and a restorative care worker, which totaled seven PSWs for the day shift, one RPN, and one RN. The home had eight-hour shifts, from 0700 hour(hr) to 1500hr; 1500hr to 2300hr; and 2300hr to 0700hr daily. The staffing level for the evening shift included five PSWs, one RPN, and one RN, and the night shift, had two PSWs and one RN.

Inspector #642 requested the scheduling and payroll department to provide documents that identified when the home did not have a full complement of PSWs over a specific period of time, (from a specific month to another specific month). Together, Inspector #642 and Office Manger reviewed the documentation, and confirmed when the home was without a full complement of PSW staff, which included;
---On a specific day in a specific month, in 2019: the day of the interview, the home had two PSW shifts not filled;
---In another specific month, in 2019: they had 21 specific shifts at a certain time; and 22.5 specific shifts at a certain time, that were unfilled PSW shifts;

---In another specific month, in 2019: they had 14 specific shifts at a certain time; and 23.5 specific shifts at a certain time, that were unfilled PSW shifts; and
---In another specific month, in 2019: they had a specific shift and a certain number of shifts; and another specific shift and a certain number of shifts, that were unfilled PSW shifts.

In summary, in a specific month, in 2019, the home failed to meet their planned staffing contingency on 25 out of 30 days, or 83 percent of the days in a specific month. The staffing deficiency in this specific month totaled 43.5 unfilled PSW shifts. The home was identified to be working shorted staff, PSWs, on specific shifts.

In another specific month, in 2019, the home failed to meet their staffing contingency on 17 out of 31 days, or 55 percent of the days in this specific month. The staffing deficiency in this specific month, totaled 37.5 unfilled PSW shifts. The home was short PSWs through this month from a specific day to another specific day, 2019, in a two-week period they were short, two and three PSW staff on certain shifts.

In another specific month, in 2019, the home failed to meet their planned staffing contingency on 11 out of 27 days, or 41 percent of the days in this specific month. The staffing deficiency in this month totaled a specific amount of unfilled PSW shifts from a specific day, to a specific day, in 2019, the home was short one PSW on a certain number of days shifts, and a certain number of evening shifts.

B) Ontario Regulation 79/10, s. 33 (1), stipulates, every licensee of a long-term care home ensures that each resident of the home is provided a certain activity of daily living (ADL), at a minimum, a certain number of times in a week by the method of his or her choice and more frequently as determined by the residents' specific requirements, unless contraindicated by a medical condition.

Inspector #642 completed a record review, and identified a document titled, "Plan B-Evening Shift"; and "Plan C- two staff short for a shift," The documents referred to the PSWs sections when they were short PSWs, and what residents they were to pick up when they were shorted staff. The Inspector identified on these two documents was a statement, stating, "No [ADL] are to be given," in a "Plan B-Evening Shift", and "Plan C-two staff short for a shift," situation.

During interviews with PSWs #108, #109, #110, #111, #112, #113, and #115, they each stated the home had been short staffed PSWs for months, and when they were short

PSWs, the residents' specific ADL were not being completed. The PSWs stated they would write, "Not applicable", or "Activity did not occur," in the Point of Care (POC) documentation record, when they could not complete a resident specific ADL due to short staffing.

Interviews with RPN #104, #106, and RNs #103, #114, indicated the home had been short PSWs daily, and when they were short two PSWs, especially on certain shifts, a specific ADL was not being completed.

The Inspector interviewed RN #114, to inquire about what the home does, when a resident misses a specific ADL and if the ADL is made up. RN #114 stated that if the ADL is made up, the PSW would have documented it in the residents electronic medical file under the POC and it would have been in the residents record.

a) Inspector #642 reviewed resident #002's documentation in the POC titled, "POC Response History." Documented under task: resident #002 preferred a, specific ADL on specific days of the week, with a specified level of physical assistance. The Inspector identified by looking back 30 days in this document, that resident #002 had not received a specific ADL in a specific month, on two specified days, in 2019.

Further review of resident #002's ADL's for a specific number of months, the Inspector reviewed another document from the POC, titled, "Follow Up Question Report," which is where the PSW records a specific ADL and if it was completed or not. The Inspector had identified, resident #002, was to receive their ADLs on a specific shift, and had missed their ADL in a specific month, on two specific days, in 2019, and another specific month on two specific days, in 2019, there was no record that any of these ADLs had been made up.

Resident #002 had missed a specific number of ADLs in a specific number of months.

b) Inspector #642 reviewed resident #003's documentation in the POC titled, "POC Response History." Documented under task: resident #003 preferred a specific ADL, on specific days of the week, with a specific level of physical assistance. The Inspector identified by looking back 30 days that resident #003 had not received a specific ADL in a specific month, on three specified days, in 2019.

Further review of #003's specific ADL for the last three months, Inspector revealed a document from POC titled, "Follow Up Question Report," and identified resident #003

was to receive this specific ADL at a certain time of the day, and there was no record that any of the ADLs had been made up.

The Inspector reviewed resident #003's progress notes in the PCC, and there was a progress note stating that on a specific day, in 2019, "[ADL]: [Resident #003] did not receive [their] [ADL] today as facility short [a number of] PSW staff members."

Resident #003 had missed a certain number of ADLs in a specific number of months.

c) Inspector #642 reviewed resident #004's documentation in the POC titled, "POC Response History." Documented under task: resident #004 preferred a specific ADL, on specific days of the week with a specified level of physical assistance. The Inspector identified by looking back 30 days that resident #004 had not received an ADL on a specific month and day, in 2019.

Further review of resident #004's ADLs for a specific number of months, the Inspector reviewed another document titled, "Follow Up Question Report." It was identified, resident #004, was to receive their ADL at a certain time of the day, and had missed their ADL in a specific month, and a specific number of days, in 2019, and there was no record that any of the ADLs had been made up.

Resident #004 had missed a certain number of ADLs in a specific number of months.

The Inspector interviewed the Administrator/Director of Care (DOC) and they identified that the home had struggled with short staffing issues for the past few months. [s. 8. (1) (b)]

2. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times.

Three Complaints were received by the Director related to insufficient staffing and resident care concerns.

Inspector #642 requested to review the Registered Nurses (RNs) schedule and was provided a document titled, "Rotation Registered Staff," it contained a certain number of months of the registered staff schedule for the period from a specific month and day, in 2019, to another specific month and day, in 2019. The Inspector reviewed these

documents, and identified that an RN was not on duty and present in the home at all times.

Inspector #642 reviewed the RN schedules with the Office Manager, and they confirmed the dates and shifts, that an RN was not working in the home. The Office Manager stated they had not scheduled an RN on site in the home 24 hours a day, because they have been short RNs and they had been filling the RN shifts with Registered Practical Nurses (RPNs) and having an RN on call. The Office Manager explained the schedule for the RNs and provided the shifts and dates the home did not have an RN in the home. The home had 3 RN shifts per day (day, evening, and night shifts) and therefore, over a month period, there was 84 RN shifts to be filled.

The Office Manager confirmed the dates and the shifts the home did not have an RN working in the home,
---Between a specific month and day, in 2019 to another specific month and day, in 2019, there were 7 RN shifts not covered;
---Between a specific month and day, in 2019 and another specific month and day, in 2019, there were 25 RN shifts not filled out of 84 shifts, for a specific period.Therefore, 30 percent of the RN shifts were not covered;
---Between a specific month and day, in 2019 and another specific month and day, in 2019, there were 17 RN shifts not filled out of 84 RN shifts, for a specific period. Therefore, 20 percent of the RN shifts were not covered;
---Between a specific month and day, in 2019 and another month and day, in 2019, there were 18 RN shifts not filled out of 84 RN shifts, for a specific period. Therefore, 21 percent of the RN shifts were not covered.

Inspector #642 observed the home from a specific month and day, in 2019, to another specific month and day, in 2019, and there was no RN working on specific shifts: which included, a specific month and day, in 2019, there was no RN working two specific shifts; another specific month and day, in 2019, on one specific shift.

In an interview with RN #114, they stated there was not always an RN working every shift, they would have RPNs covering shifts if there was no RN for a specific shift.

The Inspector interviewed Nursing Clerk #107, who stated there was no RN working the day shift on a specific month and day, in 2019. Interviews with RPNs #104, #105, and #106, identified there was no RN working a certain shift, on a specific month and day, in 2019.

The Inspector interviewed RN #103, who was in charge of the home and they confirmed there would be no RN working in the home on a certain shift, on a specific month and day, in 2019, and stated the RPNs would be running the floors, with a RN on call. The Inspector interviewed RPN #116 working on a certain shift, on a specific month and day, in 2019, who stated that there was no RN working that shift, and there was two RPNs working.

Inspector #642 interviewed the Office Manager and the Administrator/Director of Care (DOC) separately, and they stated that they had been filling in the RN shifts with RPNs, because they had been short RNs to fill the shifts and that they did not always have a RN 24 hours a day in the home. [s. 8. (3)]

Additional Required Actions:

CO # - 001, 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 31. Nursing and personal support services

Specifically failed to comply with the following:

s. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services programs.

Three complaint's had been submitted to the Director which outlined concerns related to the shortage of staff and how it was affecting the care of residents in the home.

Inspector #642 had requested the home's staffing plan, from the Office Manager and they stated, that they did not know what a staffing plan was and suggested interviewing the nurses about that, or to take a look at the nursing desk as there was a PSW book

which had "Plan B" and "Plan C" for the PSWs.

The Inspector requested a staffing plan from the nurse in charge of the home (RN #114), they stated that they where not sure what that was, but provided documents titled, "Registered staff, over time," which described what the nurse should do, when they had to call staff for overtime. Another document provided was titled, "Plan B for Days; Plan B-Evening Shift; and Plan C-two staff short for a shift," which described what the PSWs would do when they were short PSWs.

The Inspector interviewed the Administrator/DOC, and requested the home's staffing plan, and was provided with the same document that the Office Manager and RN #114 had referred to titled, "Plan B for Days; Plan B-Evening Shift; and Plan C-two staff short for a shift."

Inspector #642 had completed a record review of the home's documents that were provided, to identify if the home had a staffing plan and the documents that were provided did not set out any clear directions that included the requirements of a staffing plan.

The Inspector reviewed the requirements under the Long-Term Care Homes Act, 2007 and the Ontario Regulation 79/10, with the Administrator/DOC, to what the staffing plan should include (r. 31 (3);
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs,
(b) set out the organization and scheduling of staff shifts,
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, (including 24/7 RN coverage).
(e) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Administrator/DOC stated they did not have a staffing plan and verified they were not meeting the requirements. [s. 31. (2)]

Additional Required Actions:

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

WN #3: 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.

Three Complaints were received by the Director related to insufficient staffing and resident care concerns.

Please see Written Notification (WN) #1 for details.

Inspector #642 reviewed resident #002's documentation in the POC titled, "POC Response History." Documented under task: resident #002 preferred a certain bath, on specific days of the week, with a specified level of physical assistance. The Inspector identified by looking 30 day's back, resident #002 had not received their bath in a specific month and on specific days, in 2019.

Further review of resident #002's baths for a certain amount of months, the Inspector reviewed another document titled, "Follow Up Question Report." It was identified, resident #002, was to receive the bath at a specific time of the day, and had missed their ADL on specific days in a specific month, in 2019, and another month and specific days in 2019.

In summary resident #002 had missed a certain number of baths out of 26 baths, which

were required over a certain amount of months, in 2019, and they were identified in specific months. Therefore they had missed 23 percent of their baths. [s. 33. (1)]

2. Inspector #642 reviewed resident #003's documentation in the POC titled, "POC Response History." Documented under task: resident #003 preferred, a specific bath, on specific days, with a specified level of physical assistance. The Inspector identified by looking 30 days back, resident #003 had not received their bath on specific days in a specific month, 2019.

In summary resident #003 had missed a certain number of baths out of 27 baths, which were required during a specific number of months, in 2019, therefore they had missed 11 percent of their baths. [s. 33. (1)]

3. Inspector #642 reviewed resident #004's documentation in the POC titled, "POC Response History." Documented under task: resident #004 preferred, a specific bath on specific days, and a specified level of physical assistance. The Inspector identified by looking 30 days back, resident #004 had not received their bath on a specific month and day, in 2019.

Further review of resident #004's baths for a specific number of months, the Inspector reviewed another document tilted, "Follow Up Question Report." It was identified, resident #004, was to receive their baths at a certain time of the day, and had missed their bath on specific days in a specific month, in 2019.

In summary resident #004 had missed a certain number of baths out of 26 baths, required for a specific number of months, in 2019, therefore they had 15 percent of their baths missed.

The PSWs and RPNs and RNs identified that when the home was short PSW staff, the residents' baths were not being completed, and it was identified in resident #002, #003, and #004s, medical files that they had baths that were not completed.

The Inspector interviewed the Administrator/DOC who identified that the home had been struggling with short staffing issues for the past few months. [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 to 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, to be implemented voluntarily.

Issued on this 13th day of November, 2019

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

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Name of Inspector (ID #) / Nom de l'inspecteur (No) :	AMY GEAUVREAU (642)
Inspection No. / No de l'inspection :	2019_669642_0019
Log No. / No de registre :	016158-19, 016590-19, 016660-19
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 1, 2019
Licensee / Titulaire de permis :	Extendicare (Canada) Inc. 3000 Steeles Avenue East, Suite 103, MARKHAM, ON, L3R-4T9
LTC Home / Foyer de SLD :	Extendicare Tri-Town 143 Bruce Street, P.O. Box 999, HAILEYBURY, ON, P0J-1K0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Carol Johnson

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) (a)

Pursuant to / Aux termes de :

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

Order / Ordre :

The Licensee must be compliant with s. 8 (3) of the LTCHA.

Specifically the licensee must ensure there is at least one registered staff nurse who is both an employee of the licensee and a member of the regular nursing staff of the home is on duty and present in the home at all times.

Grounds / Motifs :

1. The licensee has failed to ensure that at least one registered nurse who was both an employee of the licensee and a member of the regular nursing staff was on duty and present in the home at all times.

Three Complaints were received by the Director related to insufficient staffing and resident care concerns.

Inspector #642 requested to review the Registered Nurses (RNs) schedule and was provided a document titled, "Rotation Registered Staff," it contained a certain number of months of the registered staff schedule for the period from a specific month and day, in 2019, to another specific month and day, in 2019. The Inspector reviewed these documents, and identified that an RN was not on duty and present in the home at all times.

Inspector #642 reviewed the RN schedules with the Office Manager, and they confirmed the dates and shifts, that an RN was not working in the home. The Office Manager stated they had not scheduled an RN on site in the home 24 hours a day, because they have been short RNs and they had been filling the

RN shifts with Registered Practical Nurses (RPNs) and having an RN on call. The Office Manager explained the schedule for the RNs and provided the shifts and dates the home did not have an RN in the home. The home had 3 RN shifts per day (day, evening, and night shifts) and therefore, over a month period, there was 84 RN shifts to be filled.

The Office Manager confirmed the dates and the shifts the home did not have an RN working in the home,
---Between a specific month and day, in 2019 to another specific month and day, in 2019, there were 7 RN shifts not covered;
---Between a specific month and day, in 2019 and another specific month and day, in 2019, there were 25 RN shifts not filled out of 84 shifts, for a specific period.Therefore, 30 percent of the RN shifts were not covered;
---Between a specific month and day, in 2019 and another specific month and day, in 2019, there were 17 RN shifts not filled out of 84 RN shifts, for a specific period. Therefore, 20 percent of the RN shifts were not covered;
---Between a specific month and day, in 2019 and another month and day, in 2019, there were 18 RN shifts not filled out of 84 RN shifts, for a specific period. Therefore, 21 percent of the RN shifts were not covered.

Inspector #642 observed the home from a specific month and day, in 2019, to another specific month and day, in 2019, and there was no RN working on specific shifts: which included, a specific month and day, in 2019, there was no RN working two specific shifts; another specific month and day, in 2019, on one specific shift.

In an interview with RN #114, they stated there was not always an RN working every shift, they would have RPNs covering shifts if there was no RN for a specific shift.

The Inspector interviewed Nursing Clerk #107, who stated there was no RN working the day shift on a specific month and day, in 2019. Interviews with RPNs #104, #105, and #106, identified there was no RN working a certain shift, on a specific month and day, in 2019.

The Inspector interviewed RN #103, who was in charge of the home and they confirmed there would be no RN working in the home on a certain shift, on a

specific month and day, in 2019, and stated the RPNs would be running the floors, with a RN on call. The Inspector interviewed RPN #116 working on a certain shift, on a specific month and day, in 2019, who stated that there was no RN working that shift, and there was two RPNs working.

Inspector #642 interviewed the Office Manager and the Administrator/Director of Care (DOC) separately, and they stated that they had been filling in the RN shifts with RPNs, because they had been short RNs to fill the shifts and that they did not always have a RN 24 hours a day in the home.

The severity of this issue was determined to be a level 3 as actual risk. The scope of the issue was a level 1, occurring occasionally. The home had a level 3 compliance history, with two previous non-compliance to the same subsection.

* written notification (WN) issued July 06, 2017, (2017_657681_0001);
* voluntary plan of correction (VPC) issued July 06 2017, (2017_657681-001).

(642)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Dec 13, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

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

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. 31. (2) Every licensee of a long-term care home shall ensure that there is a written staffing plan for the programs referred to in clauses (1) (a) and (b). O. Reg. 79/10, s. 31 (2).

Order / Ordre :

The licensee must be compliant with s. 31 (2) of the O. Reg. 79/10.

Specifically the licensee must ensure there is a written staffing plan for the nursing and personal support services programs and the plan includes:

(a) providing for a staffing mix that is consistent with residents' assessed care and safety needs,
(b) setting out the organization and scheduling of staff shifts,
(c) promoting continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,
(d) a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, (including 24/7 RN coverage).
(e) that the plan is evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

Grounds / Motifs :

1. The licensee has failed to ensure that there was a written staffing plan for the nursing and personal support services programs.

Three complaint's had been submitted to the Director which outlined concerns related to the shortage of staff and how it was affecting the care of residents in the home.

Inspector #642 had requested the home's staffing plan, from the Office Manager and they stated, that they did not know what a staffing plan was and suggested I ask the nurses about that, or to take a look at the nursing desk as there was a

PSW book which had, "Plan B" and, "Plan C" for the PSWs.

The Inspector requested a staffing plan from the nurse in charge of the home (RN #114), they stated that they where not sure what that was, but provided documents titled, "Registered staff, over time," which described what the nurse should do, when they had to call staff for overtime. Another document provided was titled, "Plan B for Days; Plan B-Evening Shift; and Plan C-two staff short for a shift," which described what the PSWs would do when they were short PSWs.

The Inspector had interviewed the Administrator/DOC, and requested the home's staffing plan, and was provided with the same document that the Office Manager and RN #114 had referred to titled, "Plan B for Days; Plan B-Evening Shift; and Plan C-two staff short for a shift."

Inspector #642 had completed a record review of the home's documents that were provided, to identify if the home had a staffing plan and the documents that were provided did not set out any clear directions that included the requirements of a staffing plan.

Inspector reviewed the requirements under the Long-Term Care Homes Act, 2007 and the Ontario Regulation 79/10, with the Administrator/DOC, to what the staffing plan should include (r. 31 (3);
(a) provide for a staffing mix that is consistent with residents' assessed care and safety needs,
(b) set out the organization and scheduling of staff shifts,
(c) promote continuity of care by minimizing the number of different staff members who provide nursing and personal support services to each resident,
(d) include a back-up plan for nursing and personal care staffing that addresses situations when staff cannot come to work, (including 24/7 RN coverage).
(e) get evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices.

The Administrator/DOC stated they did not have a staffing plan and verified they were not meeting the requirements.

The severity of this issue was determined to be a level 2 as minimal harm or minimal risk. The scope of the issue was a level 3, which identified as

widespread. The home had a level 2 compliance history, with previous non compliance to a different subsection.

(642)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Dec 13, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l'inspecteur

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

Order # / Ordre no : 003

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 compliant with O. Reg. 79.10, s. 8 (1) (b).

The licensee shall prepare, submit and implement a plan to ensure that there is an organized program of 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:

1. How the licensee will review and revise staffing patterns for each unit in the home; related to the needs of all residents;

2. How the licensee will recruit and retain staff who provide nursing and personal support services in order to meet the needs of the residents.

Please submit the written plan, by quoting inspection number 2019_669642_0019 and inspector Amy Geauvreau by email to SudburySAO.moh@ontario.ca by November 15, 2019

Please ensure that the submitted plan written does not contain any PI/PHI.

Grounds / Motifs :

1. 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.

Three complaints had been submitted to the Director which outlined concerns related to the shortage of staff and how it was affecting the care of residents in the home.

A) Inspector #642 interviewed Resident Assessment Instrument (RAI) Coordinator #102, who identified the normal staffing level for the home of 60 residents with two units. The home had three Personal Support Workers (PSWs) for each unit, and a restorative care worker, which totaled seven PSWs for the day shift, one RPN, and one RN. The home had eight-hour shifts, from 0700 hour(hr) to 1500hr; 1500hr to 2300hr; and 2300hr to 0700hr daily. The staffing level for the evening shift included five PSWs, one RPN, and one RN, and the night shift, had two PSWs and one RN.

Inspector #642 requested the scheduling and payroll department to provide documents that identified when the home did not have a full complement of PSWs over a specific period of time, (from a specific month to another specific month). Together, Inspector #642 and Office Manger reviewed the documentation, and confirmed when the home was without a full complement of PSW staff, which included;
---On a specific day in a specific month, in 2019: the day of the interview, the home had two PSW shifts not filled;
---In another specific month, in 2019: they had 21 specific shifts at a certain time; and 22.5 specific shifts at a certain time, that were unfilled PSW shifts;
---In another specific month, in 2019: they had 14 specific shifts at a certain time; and 23.5 specific shifts at a certain time, that were unfilled PSW shifts; and

---In another specific month, in 2019: they had a specific shift and a certain number of shifts; and another specific shift and a certain number of shifts, that were unfilled PSW shifts.

In summary, in a specific month, in 2019, the home failed to meet their planned staffing contingency on 25 out of 30 days, or 83 percent of the days in a specific month. The staffing deficiency in this specific month totaled 43.5 unfilled PSW shifts. The home was identified to be working shorted staff, PSWs, on specific shifts.

In another specific month, in 2019, the home failed to meet their staffing contingency on 17 out of 31 days, or 55 percent of the days in this specific month. The staffing deficiency in this specific month, totaled 37.5 unfilled PSW shifts. The home was short PSWs through this month from a specific day to another specific day, 2019, in a two-week period they were short, two and three PSW staff on certain shifts.

In another specific month, in 2019, the home failed to meet their planned staffing contingency on 11 out of 27 days, or 41 percent of the days in this specific month. The staffing deficiency in this month totaled a specific amount of unfilled PSW shifts from a specific day, to a specific day, in 2019, the home was short one PSW on a certain number of days shifts, and a certain number of evening shifts.

B) Ontario Regulation 79/10, s. 33 (1), stipulates, every licensee of a long-term care home ensures that each resident of the home is provided a certain activity of daily living (ADL), at a minimum, a certain number of times in a week by the method of his or her choice and more frequently as determined by the residents' specific requirements, unless contraindicated by a medical condition.

Inspector #642 completed a record review, and identified a document titled, "Plan B-Evening Shift"; and "Plan C- two staff short for a shift," The documents referred to the PSWs sections when they were short PSWs, and what residents they were to pick up when they were shorted staff. The Inspector identified on these two documents was a statement, stating, "No [ADL] are to be given," in a "Plan B-Evening Shift", and "Plan C- two staff short for a shift," situation.

During interviews with PSWs #108, #109, #110, #111, #112, #113, and #115, they each stated the home had been short staffed PSWs for months, and when they were short PSWs, the residents' specific ADL were not being completed. The PSWs stated they would write, "Not applicable", or "Activity did not occur," in the Point of Care (POC) documentation record, when they could not complete a resident specific ADL due to short staffing.

Interviews with RPN #104, #106, and RNs #103, #114, indicated the home had been short PSWs daily, and when they were short two PSWs, especially on

certain shifts, a specific ADL was not being completed.

The Inspector interviewed RN #114, to inquire about what the home does, when a resident misses a specific ADL and if the ADL is made up. RN #114 stated that if the ADL is made up, the PSW would have documented it in the residents electronic medical file under the POC and it would have been in the residents record.

a) Inspector #642 reviewed resident #002's documentation in the POC titled, "POC Response History." Documented under task: resident #002 preferred a, specific ADL on specific days of the week, with a specified level of physical assistance. The Inspector identified by looking back 30 days in this document, that resident #002 had not received a specific ADL in a specific month, on two specified days, in 2019.

Further review of resident #002's ADL's for a specific number of months, the Inspector reviewed another document from the POC, titled, "Follow Up Question Report," which is where the PSW records a specific ADL and if it was completed or not. The Inspector had identified, resident #002, was to receive their ADLs on a specific shift, and had missed their ADL in a specific month, on two specific days, in 2019, and another specific month on two specific days, in 2019, there was no record that any of these ADLs had been made up.

Resident #002 had missed a specific number of ADLs in a specific number of months.

b) Inspector #642 reviewed resident #003's documentation in the POC titled, "POC Response History." Documented under task: resident #003 preferred a specific ADL, on specific days of the week, with a specific level of physical assistance. The Inspector identified by looking back 30 days that resident #003 had not received a specific ADL in a specific month, on three specified days, in 2019.

Further review of #003's specific ADL for the last three months, Inspector revealed a document from POC titled, "Follow Up Question Report," and identified resident #003 was to receive this specific ADL at a certain time of the day, and there was no record that any of the ADLs had been made up.

The Inspector reviewed resident #003's progress notes in the PCC, and there was a progress note stating that on a specific day, in 2019, "[ADL]: [Resident #003] did not receive [their] [ADL] today as facility short [a number of] PSW staff members."

Resident #003 had missed a certain number of ADLs in a specific number of months.

c) Inspector #642 reviewed resident #004's documentation in the POC titled, "POC Response History." Documented under task: resident #004 preferred a specific ADL, on specific days of the week with a specified level of physical assistance. The Inspector identified by looking back 30 days that resident #004 had not received an ADL on a specific month and day, in 2019.

Further review of resident #004's ADLs for a specific number of months, the Inspector reviewed another document titled, "Follow Up Question Report." It was identified, resident #004, was to receive their ADL at a certain time of the day, and had missed their ADL in a specific month, and a specific number of days, in 2019, and there was no record that any of the ADLs had been made up.

Resident #004 had missed a certain number of ADLs in a specific number of months.

The Inspector interviewed the Administrator/Director of Care (DOC) and they identified that the home had struggled with short staffing issues for the past few months.

The severity of this issue was determined to be a level 2 as minimal harm or minimal risk. The scope of the issue was a level 2, which identified as a pattern. The home had a level 2 compliance history, with previous non compliance to a different subsection.
(642)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

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

Ordre(s) de l’inspecteur

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

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Dec 13, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

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

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

The written request for review must include,

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

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

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

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

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

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 1st day of November, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amy Geauvreau

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